

MEDICAL ETHICS EDUCATION IN BRITAIN, 1963–1993

The transcript of a Witness Seminar held by the Wellcome Trust Centre
for the History of Medicine at UCL, London, on 9 May 2006

Edited by L A Reynolds and E M Tansey

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Technology Transfer in Britain: The case of monoclonal antibodies; Self and Non-Self: A history of autoimmunity; Endogenous Opiates; The Committee on Safety of Drugs • Making the Human Body Transparent: The impact of NMR and MRI; Research in General Practice; Drugs in Psychiatric Practice; The MRC Common Cold Unit • Early Heart Transplant Surgery in the UK • Haemophilia: Recent history of clinical management • Looking at the Unborn: Historical aspects of obstetric ultrasound • Post Penicillin Antibiotics: From acceptance to resistance? • Clinical Research in Britain, 1950–1980 • Intestinal Absorption • Origins of Neonatal Intensive Care in the UK • British Contributions to Medical Research and Education in Africa after the Second World War • Childhood Asthma and Beyond • Maternal Care • Population-based Research in South Wales: The MRC Pneumoconiosis Research Unit and the MRC Epidemiology Unit • Peptic Ulcer: Rise and fall • Leukaemia • The MRC Applied Psychology Unit • Genetic Testing • Foot and Mouth Disease: The 1967 outbreak and its aftermath • Environmental Toxicology: The legacy of *Silent Spring* • Cystic Fibrosis • Innovation in Pain Management • The Rhesus Factor and Disease Prevention • The Recent History of Platelets in Thrombosis and Other Disorders • Short-course Chemotherapy for Tuberculosis • Prenatal Corticosteroids for Reducing Morbidity and Mortality after Preterm Birth • Public Health in the 1980s and 1990s: Decline and rise? • Cholesterol, Atherosclerosis and Coronary Disease in the UK, 1950–2000 • Development of Physics Applied to Medicine in the UK, 1945–1990 • Early Development of Total Hip Replacement • The Discovery, Use and Impact of Platinum Salts as Chemotherapy Agents for Cancer • Medical Ethics Education in Britain, 1963–1993

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WITNESS SEMINARS: MEETINGS AND PUBLICATIONS¹

In 1990 the Wellcome Trust created a History of Twentieth Century Medicine Group, associated with the Academic Unit of the Wellcome Institute for the History of Medicine, to bring together clinicians, scientists, historians and others interested in contemporary medical history. Among a number of other initiatives the format of Witness Seminars, used by the Institute of Contemporary British History to address issues of recent political history, was adopted, to promote interaction between these different groups, to emphasize the potential benefits of working jointly, and to encourage the creation and deposit of archival sources for present and future use. In June 1999 the Governors of the Wellcome Trust decided that it would be appropriate for the Academic Unit to enjoy a more formal academic affiliation and turned the Unit into the Wellcome Trust Centre for the History of Medicine at UCL from 1 October 2000. The Wellcome Trust continues to fund the Witness Seminar programme via its support for the Centre.

The Witness Seminar is a particularly specialized form of oral history, where several people associated with a particular set of circumstances or events are invited to come together to discuss, debate, and agree or disagree about their memories. To date, the History of Twentieth Century Medicine Group has held nearly 50 such meetings, most of which have been published, as listed on pages xi–xviii.

Subjects are usually proposed by, or through, members of the Programme Committee of the Group, which includes professional historians of medicine, practicing scientists and clinicians, and once an appropriate topic has been agreed, suitable participants are identified and invited. This inevitably leads to further contacts, and more suggestions of people to invite. As the organization of the meeting progresses, a flexible outline plan for the meeting is devised, usually with assistance from the meeting's chairman, and some participants are invited to 'set the ball rolling' on particular themes, by speaking for a short period to initiate and stimulate further discussion.

¹The following text also appears in the 'Introduction' to recent volumes of Wellcome Witnesses to Twentieth Century Medicine published by the Wellcome Trust and the Wellcome Trust Centre for the History of Medicine at UCL.

Each meeting is fully recorded, the tapes are transcribed and the unedited transcript is immediately sent to every participant. Each is asked to check his or her own contributions and to provide brief biographical details. The editors turn the transcript into readable text, and participants' minor corrections and comments are incorporated into that text, while biographical and bibliographical details are added as footnotes, as are more substantial comments and additional material provided by participants. The final scripts are then sent to every contributor, accompanied by forms assigning copyright to the Wellcome Trust. Copies of all additional correspondence received during the editorial process are deposited with the records of each meeting in Archives and Manuscripts, Wellcome Library, London.

As with all our meetings, we hope that even if the precise details of some of the technical sections are not clear to the non-specialist, the sense and significance of the events will be understandable. Our aim is for the volumes that emerge from these meetings to inform those with a general interest in the history of modern medicine and medical science; to provide historians with new insights, fresh material for study, and further themes for research; and to emphasize to the participants that events of the recent past, of their own working lives, are of proper and necessary concern to historians.

**Members of the Programme Committee of the
History of Twentieth Century Medicine Group, 2006–07**

Dr Tilli Tansey – Reader in History of Modern Medical Sciences, Wellcome Trust Centre for the History of Medicine at UCL (WTCHM) and Chair

Sir Christopher Booth – WTCHM, former Director, Clinical Research Centre, Northwick Park Hospital, London

Dr Robert Bud – Principal Curator of Medicine and Manager of Electronic Content, Science Museum, London

Dr Daphne Christie – Senior Research Assistant, WTCHM, and Organizing Secretary

Dr John Ford – Retired General Practitioner, Tonbridge

Professor Mark Jackson – Centre for Medical History, Exeter

Professor Ian McDonald[†] – WTCHM, former Professor of Neurology, Institute of Neurology, London

Dr Helga Satzinger – Reader in History of Twentieth Century Biomedicine, WTCHM

Professor Lawrence Weaver – Professor of Child Health, University of Glasgow, and Consultant Paediatrician in the Royal Hospital for Sick Children, Glasgow

[†]Died 13 December 2006

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As with all our meetings, we depend a great deal on our colleagues at the Wellcome Trust to ensure their smooth running: the Audiovisual Department, and the Medical Photographic Library; Mr Akio Morishima, who has supervised the design and production of this volume; our indexer, Ms Liza Furnival; and our readers, Ms Fiona Plowman and Mr Simon Reynolds. Mrs Jaqui Carter is our transcriber, and Mrs Wendy Kutner and Dr Daphne Christie assist us in running the meetings. Finally we thank the Wellcome Trust for supporting this programme.

Tilli Tansey

Lois Reynolds

Wellcome Trust Centre for the History of Medicine at UCL

HISTORY OF TWENTIETH CENTURY MEDICINE WITNESS SEMINARS, 1993–2007

- 1993 **Monoclonal antibodies**
- 1994 **The early history of renal transplantation**
Pneumoconiosis of coal workers
- 1995 **Self and non-self: A history of autoimmunity**
Ashes to ashes: The history of smoking and health
Oral contraceptives
Endogenous opiates
- 1996 **Committee on Safety of Drugs**
**Making the body more transparent: The impact of nuclear
magnetic resonance and magnetic resonance imaging**
- 1997 **Research in general practice**
Drugs in psychiatric practice
The MRC Common Cold Unit
The first heart transplant in the UK
- 1998 **Haemophilia: Recent history of clinical management**
Obstetric ultrasound: Historical perspectives
Post penicillin antibiotics
Clinical research in Britain, 1950–1980

- 1999** **Intestinal absorption**
- The MRC Epidemiology Unit (South Wales)**
- Neonatal intensive care**
- British contributions to medicine in Africa after
the Second World War**
- 2000** **Childhood asthma, and beyond**
- Peptic ulcer: Rise and fall**
- Maternal care**
- 2001** **Leukaemia**
- The MRC Applied Psychology Unit**
- Genetic testing**
- Foot and mouth disease: The 1967 outbreak and its aftermath**
- 2002** **Environmental toxicology: The legacy of *Silent Spring***
- Cystic fibrosis**
- Innovation in pain management**
- 2003** **Thrombolysis**
- Beyond the asylum: Anti-psychiatry and care in the community**
- The Rhesus factor and disease prevention**
- Platelets in thrombosis and other disorders**

- 2004 **Short-course chemotherapy for tuberculosis**
- Prenatal corticosteroids for reducing morbidity and mortality associated with preterm birth**
- Public health in the 1980s and 1990s: Decline and rise?**
- 2005 **The history of cholesterol, atherosclerosis and coronary disease, 1950–2000**
- Development of physics applied to medicine in the UK, 1945–90**
- 2006 **Early development of total hip replacement**
- The discovery, use and impact of platinum salts as chemotherapy agents for cancer**
- Medical ethics education in Britain, 1963–93**
- Superbugs and superdrugs: The history of MRSA**
- 2007 **Clinical pharmacology in the UK, c. 1950–2000**
- The resurgence of breastfeeding, 1975–2000**
- DNA fingerprinting: From discovery to database**
- The development of sports medicine in twentieth-century Britain**
- Clinical pharmacology in the UK, c. 1950–2000: industrial and regulatory aspects**

PUBLISHED MEETINGS

'...Few books are so intellectually stimulating or uplifting'.
Journal of the Royal Society of Medicine (1999) **92**: 206–8,
review of vols 1 and 2

'...This is oral history at its best...all the volumes make compulsive reading...they are, primarily, important historical records'.
British Medical Journal (2002) **325**: 1119, review of the series

Technology transfer in Britain: The case of monoclonal antibodies **Self and non-self: A history of autoimmunity**

Endogenous opiates

The Committee on Safety of Drugs

Tansey E M, Catterall P P, Christie D A, Willhoft S V, Reynolds L A. (eds)
(1997) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 1. London:
The Wellcome Trust, 135pp. ISBN 1 869835 79 4

Making the human body transparent: The impact of NMR and MRI **Research in general practice**

Drugs in psychiatric practice

The MRC Common Cold Unit

Tansey E M, Christie D A, Reynolds L A. (eds) (1998) *Wellcome*
Witnesses to Twentieth Century Medicine. Volume 2. London: The Wellcome
Trust, 282pp. ISBN 1 869835 39 5

Early heart transplant surgery in the UK

Tansey E M, Reynolds L A. (eds) (1999) *Wellcome Witnesses to*
Twentieth Century Medicine. Volume 3. London: The Wellcome Trust, 72pp.
ISBN 1 841290 07 6

Haemophilia: Recent history of clinical management

Tansey E M, Christie D A. (eds) (1999) *Wellcome Witnesses to*
Twentieth Century Medicine. Volume 4. London: The Wellcome Trust, 90pp.
ISBN 1 841290 08 4

Looking at the unborn: Historical aspects of obstetric ultrasound

Tansey E M, Christie D A. (eds) (2000) *Wellcome Witnesses to*
Twentieth Century Medicine. Volume 5. London: The Wellcome Trust, 80pp.
ISBN 1 841290 11 4

Post penicillin antibiotics: From acceptance to resistance?

Tansey E M, Reynolds L A. (eds) (2000) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 6. London: The Wellcome Trust, 71pp.
ISBN 1 841290 12 2

Clinical research in Britain, 1950–1980

Reynolds L A, Tansey E M. (eds) (2000) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 7. London: The Wellcome Trust, 74pp.
ISBN 1 841290 16 5

Intestinal absorption

Christie D A, Tansey E M. (eds) (2000) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 8. London: The Wellcome Trust, 81pp.
ISBN 1 841290 17 3

Neonatal intensive care

Christie D A, Tansey E M. (eds) (2001) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 9. London: The Wellcome Trust Centre for the History of Medicine at UCL, 84pp. ISBN 0 854840 76 1

British contributions to medical research and education in Africa after the Second World War

Reynolds L A, Tansey E M. (eds) (2001) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 10. London: The Wellcome Trust Centre for the History of Medicine at UCL, 93pp. ISBN 0 854840 77 X

Childhood asthma and beyond

Reynolds L A, Tansey E M. (eds) (2001) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 11. London: The Wellcome Trust Centre for the History of Medicine at UCL, 74pp. ISBN 0 854840 78 8

Maternal care

Christie D A, Tansey E M. (eds) (2001) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 12. London: The Wellcome Trust Centre for the History of Medicine at UCL, 88pp. ISBN 0 854840 79 6

Population-based research in south Wales: The MRC Pneumoconiosis Research Unit and the MRC Epidemiology Unit

Ness A R, Reynolds L A, Tansey E M. (eds) (2002) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 13. London: The Wellcome Trust Centre for the History of Medicine at UCL, 74pp. ISBN 0 854840 81 8

Peptic ulcer: Rise and fall

Christie D A, Tansey E M. (eds) (2002) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 14. London: The Wellcome Trust Centre for the History of Medicine at UCL, 143pp. ISBN 0 85484 84 2

Leukaemia

Christie D A, Tansey E M. (eds) (2003) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 15. London: The Wellcome Trust Centre for the History of Medicine at UCL, 86pp. ISBN 0 85484 087 7

The MRC Applied Psychology Unit

Reynolds L A, Tansey E M. (eds) (2003) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 16. London: The Wellcome Trust Centre for the History of Medicine at UCL, 94pp. ISBN 0 85484 088 5

Genetic testing

Christie D A, Tansey E M. (eds) (2003) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 17. London: The Wellcome Trust Centre for the History of Medicine at UCL, 130pp. ISBN 0 85484 094 X

Foot and mouth disease: The 1967 outbreak and its aftermath

Reynolds L A, Tansey E M. (eds) (2003) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 18. London: The Wellcome Trust Centre for the History of Medicine at UCL, 114pp. ISBN 0 85484 096 6

Environmental toxicology: The legacy of *Silent Spring*

Christie D A, Tansey E M. (eds) (2004) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 19. London: The Wellcome Trust Centre for the History of Medicine at UCL, 132pp. ISBN 0 85484 091 5

Cystic fibrosis

Christie D A, Tansey E M. (eds) (2004) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 20. London: The Wellcome Trust Centre for the History of Medicine at UCL, 120pp. ISBN 0 85484 086 9

Innovation in pain management

Reynolds L A, Tansey E M. (eds) (2004) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 21. London: The Wellcome Trust Centre for the History of Medicine at UCL, 125pp. ISBN 0 85484 097 4

The Rhesus factor and disease prevention

Zallen D T, Christie D A, Tansey E M. (eds) (2004) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 22. London: The Wellcome Trust Centre for the History of Medicine at UCL, 98pp. ISBN 0 85484 099 0

The recent history of platelets in thrombosis and other disorders

Reynolds L A, Tansey E M. (eds) (2005) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 23. London: The Wellcome Trust Centre for the History of Medicine at UCL, 186pp. ISBN 0 85484 103 2

Short-course chemotherapy for tuberculosis

Christie D A, Tansey E M. (eds) (2005) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 24. London: The Wellcome Trust Centre for the History of Medicine at UCL, 120pp. ISBN 0 85484 104 0

Prenatal corticosteroids for reducing morbidity and mortality after preterm birth

Reynolds L A, Tansey E M. (eds) (2005) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 25. London: The Wellcome Trust Centre for the History of Medicine at UCL, 154pp. ISBN 0 85484 102 4

Public health in the 1980s and 1990s: Decline and rise?

Berridge V, Christie D A, Tansey E M. (eds) (2006) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 26. London: The Wellcome Trust Centre for the History of Medicine at UCL, 101pp. ISBN 0 85484 106 7

Cholesterol, atherosclerosis and coronary disease in the UK, 1950–2000

Reynolds L A, Tansey E M. (eds) (2006) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 27. London: The Wellcome Trust Centre for the History of Medicine at UCL, 164pp. ISBN 0 85484 107 5

Development of physics applied to medicine in the UK, 1945–90

Christie D A, Tansey E M. (eds) (2006) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 28. The Wellcome Trust Centre for the History of Medicine at UCL, 141pp. ISBN 0 85484 108 3

Early development of total hip replacement

Reynolds L A, Tansey E M. (eds) (2007) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 29. London: The Wellcome Trust Centre for the History of Medicine at UCL, 198pp. ISBN 978 085484 111 0

The discovery, use and impact of platinum salts as chemotherapy agents for cancer

Christie D A, Tansey E M. (eds) (2007) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 30. London: The Wellcome Trust Centre for the History of Medicine at UCL, 121pp. ISBN 978 085484 112 7

Medical ethics education in Britain, 1963–93

Reynolds L A, Tansey E M. (eds) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 31. London: The Wellcome Trust Centre for the History of Medicine at UCL. This volume. ISBN 978 085484 113 4

Superbugs and superdrugs: The history of MRSA

Reynolds L A, Tansey E M. (eds) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 32. London: The Wellcome Trust Centre for the History of Medicine at UCL. In press. ISBN 978 085484 114 1

Clinical pharmacology in the UK, c. 1950–2000

Christie D A, Tansey E M. (eds) (2007) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 33. London: The Wellcome Trust Centre for the History of Medicine at UCL. In press.

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A hard copy of volumes 21–31 can be ordered from www.amazon.co.uk; www.amazon.com; and all good booksellers for £6/\$10 plus postage, using the ISBN.

Other publications

Technology transfer in Britain: The case of monoclonal antibodies

Tansey E M, Catterall P P. (1993) *Contemporary Record* **9**: 409–44.

Monoclonal antibodies: A witness seminar on contemporary medical history

Tansey E M, Catterall P P. (1994) *Medical History* **38**: 322–7.

Chronic pulmonary disease in South Wales coalmines: An eye-witness account of the MRC surveys (1937–42)

P D'Arcy Hart, edited and annotated by E M Tansey. (1998) *Social History of Medicine* **11**: 459–68.

Ashes to Ashes – The history of smoking and health

Lock S P, Reynolds L A, Tansey E M. (eds) (1998) Amsterdam: Rodopi BV, 228pp. ISBN 90420 0396 0 (Hfl 125) (hardback). Reprinted 2003.

Witnessing medical history. An interview with Dr Rosemary Biggs

Professor Christine Lee and Dr Charles Rizza (interviewers). (1998) *Haemophilia* **4**: 769–77.

Witnessing the Witnesses: Pitfalls and potentials of the Witness Seminar in twentieth century medicine

By E M Tansey. In: Doel R, Søderqvist T. (eds) (2006) *Writing Recent Science: The historiography of contemporary science, technology and medicine*. London: Routledge, 260–78.

INTRODUCTION

Medical ethics education in Britain has been through an interesting period in the last 40 years, and the changes, problems and excitement are well captured in this volume. Right at the beginning of this seminar, Michael Barr set the tone. He emphasised the need to be critical, in that some histories of medical ethics ‘do not question the self-subscribed necessity of secular bioethics nor do they contextualize bioethics’ own agenda, discourse and practice’. These are key aspects of all educational ventures; purpose, objectives and context.

The medical ethics curriculum in the 1960s, the starting point of this volume, is well described; essentially there was very little and what there was could be best described as the rules of etiquette for doctors. So what changed? How did it come about? How sustainable has it been? Like most things it was a combination of factors which came together at the right time.

Society was changing and patients and the public expected more from their doctor. I well recall as a new Professor of Oncology in Glasgow in 1974, that the majority of patients referred to my unit did not know the diagnosis. They had not been told. There was a feeling that this was just not good enough and the patients needed greater involvement in their own care. The Abortion Act and the surrounding debate had raised moral issues that wouldn’t go away. The powerful voices of René Dubos (1959), Henry Miller (1973), Ivan Illich (1975a), Thomas McKeown (1976), and of Ian Kennedy in his Reith Lectures (1980) caught the profession and made it feel both angry and guilty. I have written elsewhere on the powerful effect that the Reith lectures had on me.¹ At the same time the Medical Groups were developing across the country, raising the awareness in students and staff of the need to consider such issues in clinical practice. The development of the Medical Groups is especially well described in this present volume. The Todd Report of 1968 on Medical Education had again awakened interest in education and the broader aspects of the medical curriculum.²

Above all there were a range of people, many of whom attended this seminar, who were pioneers in the teaching of the subject. It is difficult to underestimate the importance of this aspect of the development of medical ethics. Like most ‘new’ subjects it is people who drive the changes and whose own personalities

¹ Calman (2007).

² Royal Commission on Medical Education (1968).

create a place and a demand for the topic. In addition it is clear that there were one or two people in senior positions (deans, college presidents, senior figures in the British Medical Association (BMA) and the General Medical Council (GMC)) who were supportive, and this element always seems to be a pre-requisite for change.

As important was the involvement of students and their backing for the various initiatives, all well recorded in this Witness Seminar, especially in the Medical Groups around the country. The discussion at these meetings made a difference to them and, in many instances, it was the student who carried the torch onwards and upwards. The development of the Society for the Study of Medical Ethics (SSME, later the Institute of Medical Ethics), and the publication of the *Journal of Medical Ethics* raised the awareness of the current issues and provided a forum for communication and debate.

In the middle of the 1980s there was another development that was complementary to medical ethics teaching – not fully discussed in this seminar – and grew out the same roots: the arts and humanities in health and medicine.³ This broadened the base of the teaching.

The Pond *Report* (1987), which reviewed the teaching of medical ethics in Britain, was particularly important.⁴ I looked through my own copy of this Report recently, together with the GMC's *Tomorrow's Doctors* (1993).⁵ The Pond *Report* begins with the obvious point:

It is often claimed that medical ethics cannot be taught. Competence and compassion, it is argued, are acquired by experience or 'osmosis', while the moral views of individuals differ and ultimately are a personal matter.⁶

It then raises the question as to whether or not this is true, and asks if there is a place in medical education for ethics as a subject. The report then sets out how such a subject might be part of the medical curriculum. It defines the two meanings of medical ethics. The first relates to standards of professional

³ Calman *et al.* (1988).

⁴ Boyd (ed.) (1987) and chaired by Sir Desmond Pond. See Figure 10, page 57.

⁵ General Medical Council, Education Committee (1993). See Figure 8, page 39.

⁶ Boyd (ed.) (1987): 1.

competence and conduct. The second refers to the study of ethical or moral problems raised by medical practice. It is this second meaning which began to receive more prominence and included not only patient issues, but those related to public health. One key part of the learning was to allow:

Greater awareness and understanding, on the part of doctors, of their own and others' moral thinking, thus have an important part to play in facilitating better communication, not only between doctors and patients, and doctors and other health professionals, but also among doctors themselves.⁷

Of particular interest in the present volume was that the Pond Working Party reviewed existing practice in medical schools in the UK by writing to the Deans of the 30 medical schools enclosing a questionnaire. The results of the survey showed significant variation and that overall the total number of time-tabled hours in the subject was not large. Ethics teaching was encouraged, particularly in obstetrics, general practice, and community medicine and, in a few schools, short ethics courses had been introduced. Very few medical teachers appear to have had any specific training in medical ethics.

The *Report* made a number of recommendations which in summary were:

- Medical ethics teaching should be taught at regular intervals throughout the medical course.
- Clinical teaching of ethics should normally begin from clinical examples and small group discussion should be emphasized.
- Interested medical teachers should be encouraged to undertake further study.
- Multidisciplinary ethics teaching should be encouraged.
- Care should be taken to ensure that teaching is not undertaken by persons who hold particular views and promote a personal agenda.
- Examinations or other assessment should reflect an interest in ethics.
- Elective courses should be arranged for interested students.¹

⁷ Boyd (ed.) (1987): 3.

Such recommendations were a valuable spur to improving the learning experience of students. Since that *Report* there have been numerous papers on the methods and resources available for the teaching of medical ethics.⁸

The GMC report *Tomorrow's Doctors* of 1993 was a positive response to the atmosphere at the time and emphasized the importance of ethics and communication skills, and the doctor's moral and ethical responsibilities. This important publication ends the time period covered in this seminar, but the question remains as to what has happened since and what further questions remain at the end of this seminar?

Several issues are raised by this report:

1. The importance of people and their personal influence. It is clear that little would have happened without such people who were passionate about the subject and who encouraged its development.
2. One issue raised in the Pond *Report* was the capacity and capability of teachers who could assist students in the learning process. I suspect that this remains as an issue today. There are new opportunities through the Academy of Higher Education, The Association for the Study of Medical Education or the newly formed Academy of Medical Educators to build alliances and increase the size and quality of the pool of people able to facilitate learning.
3. Were Michael Barr's questions answered? Perhaps not. A key issue is to define the purpose of learning medical ethics, and not to see it only as the responsibility of a few dedicated individuals who believe that it is worthwhile. We need to define the purpose more clearly. In addition if ethics as a subject is to be part of the medical course then a discussion on the curriculum is essential, which would include, for example the methods to be used, resources available and how much 'moral philosophy' is required. The assessment of students is also an essential part of this process.

Is it time, therefore, for another review?

As it happens following the recommendations of a recent national consultation on medical ethics in medical education (2006), the Institute of Medical Ethics

⁸ See, for example, the Royal College of General Practitioners' *Clinical Ethics and Values-based Practice*, Curriculum Statement 3.3, freely available at www.rcgp-curriculum.org.uk/PDF/curr_3_3_Ethics_2006.pdf (visited 19 June 2007).

proposes to undertake, in collaboration with other stakeholders, a review and programme of work designed to promote best practice in, and provide resources for teaching, learning and assessment of medical ethics and law across UK medical schools. Perhaps this will take us a stage further and build on the remarkable pioneering work described in this Witness Seminar transcript.

Kenneth C Calman
University of Glasgow

MEDICAL ETHICS EDUCATION IN BRITAIN, 1963–1993

The transcript of a Witness Seminar held by the Wellcome Trust Centre
for the History of Medicine at UCL, London, on 9 May 2006

Edited by L A Reynolds and E M Tansey

MEDICAL ETHICS EDUCATION IN BRITAIN, 1963–1993

Participants

Professor Tom Arie	Dr Stephen Lock (Chair)
Dr Michael Barr	Sir Malcolm Macnaughton
Professor Sir Christopher Booth	Dr Diana Manuel
Professor Kenneth Boyd	Dr David Misselbrook
Fr Brendan Callaghan	Professor David Morton
Professor Alastair Campbell	Dr Richard Nicholson
Professor Donna Dickenson	Dr Brian Payne
Mrs Iris Fudge	Professor Povl Riis
Professor Bill Fulford	The Very Revd Edward Shotter
Professor Stanley Gelbier	Dr Ian Tait
Professor Raanan Gillon	Dr Tilli Tansey
Professor Roger Higgs	The Revd Bryan Vernon
Professor Bryan Jennett	Dr Peter Wilkinson
Professor Sir Ian Kennedy	Dr Michael Wilks

Among those attending the meeting: Dr Oonagh Corrigan, Professor Martyn Evans, Dr Adam Hedgecoe, Mr Donald Hill, Professor Alan Petersen, Dr Janet Radcliffe Richards, Dr Robert Song, Professor Jeffrey Tobias, Dr Mark Walport, Professor Lawrence Weaver, Mr Neil Weir, Dr Tony Woods

Apologies include: Dr Richard Ashcroft, Miss Talitha Bolton, Professor Sir Robert Boyd, Professor Sir Kenneth Calman, Sir Liam Donaldson, Professor Robin Downie, Dr Donald Evans, Professor Dorian Haskard, Sir Raymond Hoffenberg,[†] Professor Tony Hope, Professor Lene Koch, Dr David Lamb, Professor John Ledingham, Professor Margaret Lloyd, Dr Patrick Magee, Professor Sheila McLean, Professor Michael Parker, Professor Ed Peile, Dr Anne-Marie Slowther, Lord Turnberg, Baroness Warnock, Dr Simon Woods

[†]Died 22 April 2007

Dr Tilli Tansey: Good afternoon, ladies and gentlemen. May I welcome you to this Witness Seminar on medical ethics education in Britain, 1963–93. I am the Convenor for the History of Twentieth Century Medicine Group, which was established by the Wellcome Trust in 1990 to bring together clinicians, scientists, historians of medicine and others interested in what we would call the recent history of medicine, post-Second World War.

This meeting came about because of a suggestion made to me by Michael Barr. In addition to identifying and locating participants to take part in this meeting, we do of course spend a long time thinking about who could chair the meeting, and we are delighted that Dr Stephen Lock, the former editor of the *British Medical Journal*, has agreed to chair this meeting and so I hand the meeting over to him.

Dr Stephen Lock: When I joined the BMJ as a very junior person, a colleague, said to me: ‘Whenever any of us begins to talk about medical ethics, the time has come for that person to retire’. Since then, several things have happened to make the subject of obvious importance. Most importantly, of course, medical ethics has advanced, becoming concerned with real problems instead of those surrounding the size of nameplates and not criticizing colleagues. What’s more, many of us in this room have matured to the age when even formerly it was considered proper to talk about the subject. So it’s particularly relevant, I think, that one of Tilli’s splendid Witness Seminars has decided to consider the subject, and even better that her fame and the reputation of the seminars has attracted the knowledgeable audience that we have here this afternoon. Without more ado, then, I’ll hand you over to Michael Barr, whose perspective as a younger expert on the subject seems a particularly good way of launching our discussion.

Dr Michael Barr: I want to begin with the obvious and that is to thank the Wellcome Trust’s History of Twentieth Century Medicine Group for agreeing to sponsor this seminar. Especially I am grateful to Tilli Tansey, Daphne Christie and Wendy Kutner for their efforts in organizing the meeting, and to Stephen Lock for agreeing to chair it.

It is bit embarrassing that the historical adviser was in fact still in nappies when many of the events we’ll be discussing took place. So I am just going to listen today, but I do want very briefly to explain the rationale for the meeting.

I proposed the history of medical ethics education to the History of Twentieth Century Medicine Group in part because I thought conventional histories of

bioethics were lacking in a couple of ways.¹ The conventional view, after all, attributes the rise of the field to a combination of factors, including: the impact of the Second World War;² the effect of ‘whistle-blowers’ such as Beecher and Pappworth;³ the impact of new technologies, which created unprecedented moral dilemmas – for example, Albert Jonsen, a former Jesuit priest who taught bioethics at the Universities of California at San Francisco and Washington;⁴ and the rise of minority social movements that carried over into new demands for patients’ rights (see, for example, the work of David Rothman, Professor of Social Medicine and Director of the Center for the Study of Society and Medicine at the Columbia College of Physicians and Surgeons, New York).⁵

All of this is very important but most histories of biomedical ethics, it seems to me, tend to lack a critical edge – that is they do not question the self-subscribed necessity of secular bioethics, nor do they contextualize bioethics’ own agenda, discourse and practice. And even in those historical accounts that are critical, as in the case of Tina Stevens’ work on the Hastings Center, they are still very much American.⁶ Along with many others, I had a feeling that our colleagues across the pond [the US] were stealing the show as to the birth of bioethics and this should not be permitted. (You may hear the irony in my voice as I am an American myself, so my apologies and please excuse the accent as an accident of birth.)

In a nutshell, the time is overdue for us here in the UK to become the storytellers and to provide a corrective to accounts from across the pond. Much

¹ These terms, medical ethics and bioethics, have their own history. See, for example, Barr (2003): 82, note 1. For one historian’s view of the field, see Cooter (1995).

² Dr Kenneth Mellanby published a volume entitled *Human Guinea Pigs* in 1945, describing the wartime experiments on pacifists and conscientious objectors at the Sorby Research Institute in Sheffield. A second edition with additional material appeared in 1973, where Mellanby noted that Pappworth’s book of the same name mentioned neither his book, nor the earlier work on scabies, malaria or vitamin C deprivation. See Mellanby (1973): 5–17.

³ Beecher (1959) and Pappworth (1967) are the ‘whistle-blowers’, the first modern published warnings to the medical profession of unacceptable research on human subjects.

⁴ Jonsen (1968, 1998); Jonsen and Toulmin (1988). See biographical note on page 181.

⁵ Rothman (1987, 1991, 1995). See also Edelson (2000).

⁶ Stevens (2000). The Hastings Center, Garrison, NY, is an independent, non-partisan, and non-profit bioethics research institute founded in 1969 as the Institute of Society, Ethics and the Life Sciences. The *Hastings Center Report*, a bi-monthly journal, has been indexed by PubMed since 1971. See www.thehastingscenter.org/default.asp (visited 10 January 2007).

work has been done on eighteenth-century British medical ethics, The Revd Thomas Percival [1740–1804] and John Gregory [1724–73], for example, and on the history of the General Medical Council (GMC) and the British Medical Association (BMA) Ethics Committee.⁷ However, there has been little systematic effort to document the history of postwar medical ethics in the UK, despite being a funding priority of the Wellcome Trust for some time now, since 1997.⁸

It makes sense to start with the Medical Groups, given the fundamental role of education in the profession. There are limits to what we can accomplish in one afternoon. Sadly, some key figures such as Sir Douglas Black and The Revd Professor Gordon Dunstan have already left us.⁹ But recording the first-hand testimonies of those involved is the first crucial chapter in telling this story. Only after we have it straight from the source can we begin to relate those accounts to the published records and archives, and then do the interpretive work to analyse the dramatic growth of this field, as it happened in Britain.

So that was my rationale for proposing today's seminar. And with that, I hand over to Dr Stephen Lock, whose wisdom on these matters far exceeds my own.

⁷ Percival (1803); Howard (1975); Gregory (1788); Pyke-Lees (1958); Smith (1993); Baker (1993); Baker (ed.) (1995); Morrice (2002); Stacey (1992). See also Faden and Beauchamp (1986): 61–113. For a sociological perspective, see Waddington (1975).

⁸ Dr Tony Woods wrote: "The Wellcome Trust Biomedical Ethics (BME) programme was established in 1997 to provide funding for research into the ethical, legal, social and public policy implications of advances in biomedical science, ostensibly in the areas of genetics and neuroscience (including mental health), although broader areas are now covered. Since then the programme has provided funding for project grants, studentships and post-doctoral fellowships at a cost of £14.7m. The field of biomedical ethics should be taken to cover ethical issues that arise in the development and delivery of healthcare, or that arise from the use of medical techniques. This includes ethics of research (involving either humans or animals); ethical issues in the translation of research into practice; ethical issues arising in clinical care; and ethical issues arising from the delivery of care including policy and public health. Biomedical ethics is important for the Wellcome Trust's mission and strategic aims. If advances in biomedical knowledge are to have maximum health benefit and to engage society then it will be important to identify and explore the ethical issues that arise from new scientific knowledge and from the scrutiny of medicine and research by the wider society. Research in ethics is also important in supporting the Trust's long-standing and continuing interest in global health and in funding research in developing countries. The Trust has indeed explicitly identified the medical humanities (which include ethics) as an important area of research "to improve our understanding of the historical, ethical, social and cultural context in which biomedical research and its application take place".' E-mail to Mrs Lois Reynolds, 3 April 2007. For details of the Wellcome Trust's Biomedical Ethics Programme, see www.wellcome.ac.uk/node1016.html (visited 5 June 2007).

⁹ See biographical notes, pages 171 and 175–6.

Lock: Thank you very much. As Michael has said, there were a large number of factors influencing the beginnings of the teaching of medical ethics and I do emphasize that this meeting is about teaching rather than medical ethics per se, or we shall be here for the whole week.

Inevitably I think all of us would probably disagree about why it started. And I have to tell you about my own hang-up, because when I went to the *British Medical Journal (BMJ)*, my first boss was Hugh Clegg, who had been obsessed with the need for informed consent in trials.¹⁰ He had sent a reporter to Nuremberg, learnt about the Nuremberg Code – subsequently modified into the Declaration of Geneva – and in 1964 when I went to the *BMJ* he had just collaborated with Dr Tapani Kosonen, a Finnish physician, still alive in his late eighties, to prepare the new Declaration of Helsinki.¹¹ Hugh was very much obsessed with that.

But our plan this afternoon is to look at the beginnings of teaching medical ethics, and how it all suddenly became formalized – if one's allowed to use that word as a verb. I hope we won't have a narrow focus, because we have here people from different and related disciplines, nursing, dentistry, animal experimentation, and I hope we shall have at least a short look at some of these. Teaching was also important in many other countries, and I think at least we ought to see what was going on in the US, as several of you here went there in those days. Some of you will have said not very much, but at least we can find out just what was happening elsewhere. Fortunately, we have many experts here who were around at the time.

I am noted for being facetious and in my facetious way I see today's assembly as being rather like the famous Diaghilev ballet. It's a pity that Baroness Warnock isn't here today.¹² I am sure she wouldn't have taken offence if I had compared her with Pavlova. Ian Kennedy, whom we expect any time, was certainly the Stravinsky of the group. Those of you who remember his 1980 Reith Lectures,

¹⁰ The Draft Code of Ethics on Human Experimentation was put forward in 1961 by the WMA's Medical Ethics Committee, chaired by the then Editor of the *British Medical Journal*, Dr Hugh Clegg, and adopted by the 18th Assembly as the Declaration of Helsinki in 1964. See Clegg (1960); Pappworth (1990): 1457. For a discussion of available sources, see the August 2004 *Bulletin of Medical Ethics* at www.bullmedeth.info/200.htm (visited 30 May 2007). See also Bynum (1988); Hazelgrove (2002).

¹¹ The Declaration of Helsinki is a statement of ethical principles developed by the WMA to 'provide guidance to physicians and other participants in medical research involving human subjects' [WMA (1996): 197, para 1]. See Glossary, page 194. See also Vollmann and Winau (1996); Faden and Beauchamp (1986).

¹² See, for example, Committee of Inquiry into Human Fertilisation and Embryology (1985). Baroness Warnock, Chairman. See also Warnock (1984); Doyal *et al.* (1998).

Unmasking Medicine,¹³ will know it had very much the same effect on the doctors as *The Rite of Spring* had on the audience in the Théâtre des Champs-Élysées just before the First World War.¹⁴ I would like to introduce you to our Nijinsky, whom you probably won't know – this is my old friend Professor Povl Riis, from Copenhagen, Denmark, who is Emeritus Professor of Medicine at the University of Copenhagen, and a Fellow of the Royal College of Physicians of London (FRCP). Crucially, as we will hear, he introduced the teaching of medical ethics into the curriculum, not only in Copenhagen, but then spread it across the other Danish medical schools, and later throughout the Nordic countries. And today he is responsible to the World Health Organization (WHO) for revising their Declaration of Helsinki. Now, little advance would have been made in the field of ballet without Sergei Diaghilev; he put the subject on a map, he changed our society's perception, not just of ballet, but of all the arts as well, and many other aspects of everyday life such as advertising, and the pressure, the constant pressure for newness, owes a lot to Diaghilev. We have a Diaghilev for medical ethics – Ted Shotter, sitting there in the second row, looking rather pensive – but I think without Ted 'Diaghilev' Shotter, I wonder if we would be here today. So without more ado, I would like to ask you, Ted, to tell us about the early days of the informal teaching of medical ethics.

The Very Revd Edward Shotter: Thank you, I will pretend that is a compliment. Well, now, it was all by accident, rather than by design. Having been a dockyard curate in Plymouth, I was brought to London in 1962 by the Student Christian Movement (SCM), as one of their intercollegiate secretaries, that is, a sort of ecumenical chaplain. Very shortly after I got here, I was told that there had been a survey of medical education, undertaken by an American, Andrew Mephram, a Columbia-trained physician, and chaplain of the Littlemore Hospital in Oxford.¹⁵ And in essence his recommendation was that medical students should

¹³ Kennedy (1980). The lectures were originally printed in six weekly issues of *The Listener* **104** (1980), nos 2686–91.

¹⁴ *The Rite of Spring [Le Sacre du Printemps]*, by Igor Stravinsky (1882–1971) was commissioned by Sergei Diaghilev for his Ballets Russes, to be staged by Michel Fokine and choreographed by Vaslav Nijinsky, and was first performed on 29 May 1913. The shocking music and primitive movements outraged the audience, whose shouts and fights stopped the performance. In 1914 the score was included in a concert and by 1929 its significance was proclaimed in the press and further secured when a section was used in Walt Disney's cartoon *Fantasia* in 1940.

¹⁵ Andrew Mephram's survey of British medical schools for the SCM indicated a need for a service dealing with issues raised through the practice of medicine which concern the theologian, philosopher and sociologist, as well as the doctor. See Appendix 1, page 76. See also *LMG Annual Report 1965*: 5; *LMG Annual Report 1967/8*: 1.

be seen as part of the teaching hospital and not as part of the university in the dealings of the SCM. I think the important thing about the SCM in this context is that it concerned itself with dialogue and it concerned itself with ‘taking the university seriously’. I was introduced to two or three medical students at the Royal Free and St Mary’s Hospital Medical Schools, and began discussing with them how we might proceed.¹⁶ And I discovered to my astonishment that there was no teaching in ethics in British medical education. Later I was to wonder whether there was any in US medical education either. I had done ethics (moral philosophy) with my BA, I had done ethics (moral theology) when training for ordination, and I ‘knew’ doctors took the Hippocratic Oath as everybody knew, and when I found that there was no such thing, and when I found that medical ethics, as a term, was misunderstood in my book, I wondered whether I could do something about it.¹⁷ Without any further ado, and certainly with no further definition, and not even knowing at that point that ethics had been subsumed to etiquette in the thinking of the profession, I put on four lectures in what I thought and those students thought might be medical ethics.¹⁸ It so happened that one of those who had been advising Andrew Mepham was Cicely Saunders, so she gave one of the first lectures for the London Medical Group (LMG), on pain.¹⁹ She was to lecture on that topic, at the request of clinical students under the auspices of the LMG, for the next 25 or 26 years. The lecture became a classic, because it followed the development and the emergence of palliative care as a sub-specialty.²⁰

Enough people came to those first four lectures, and I published their names and titles on a card. The card had the same front cover as those on your chair.²¹ I drew the letters LMG – I couldn’t afford the artwork, the £7.50 that it would cost – at 3 o’clock in the morning with a Parker 51 [a modern fountain pen by

¹⁶ See Appendix 1, page 77.

¹⁷ The Hippocratic Oath is still sworn by new physicians. See Nutton (1995).

¹⁸ See Appendix 1, page 77.

¹⁹ See biographical note on page 188. See also Reynolds and Tansey (eds) (2004).

²⁰ Dr Cicely Saunders, then at St Thomas’ Hospice, London, spoke at the fourth open meeting during the first year of the LMG, on 17 March 1964 at 5.30pm at the London Hospital Medical School.

²¹ A copy of an LMG annual programme was among the papers available to those attending the meeting. These were collected at the meeting’s close and make up part of the LMG archive held at SA/IME, Archives and Manuscripts, Wellcome Library, London. For an example of the programme, see Appendix 3, pages 122–6.



Figure 1: Lord Amulree, Chairman of the Governing Body of the London Medical Group from 1968–81.

the Wisconsin-based Parker Pen Company introduced in 1941], had it reverse-blocked and that served as the colophon, the distinguishing characteristic, of the LMG, and the way we advertised it for the whole of its lifespan. People came for the first year, in significant numbers – I probably mean only a dozen or a dozen and a half, not all medical students, but a cross-section of the hospital community, nursing staff, House Officers, administrative personnel – but it was enough to have another go, and the following year we put on eight lectures, and in the third year we put on 21 lectures.

By this time, the cost of the exercise had outrun the interest of the SCM in it, so the LMG became an independent body. A governing body was set up, of which Lord Amulree was chairman.²² The next thing to note is that in developing the LMG programme, all the topics were identified by students and none handed

²² The Very Revd Edward Shotton wrote: 'Lord Amulree was a founding father of geriatric medicine in the UK, and Liberal Chief Whip in the House of Lords'. Note on draft manuscript, 12 November 2006. See biographical note on page 169.

down by authority, we had a multidisciplinary advisory group which identified the speakers. Our understanding was that students only know those people who teach them, and could not possibly know cutting-edge speakers in the topics they were identifying. Something that has been identified as the medical group method began to emerge: a representative council of students identifying the topics, a consultative council of senior advisers identifying the speakers. And that was developed and replicated in subsequent medical groups.

The first medical group after London was the Edinburgh Medical Group, in Edinburgh because I knew Kenneth Boyd, who is sitting next to me, and didn't know anyone else in a medical centre. And because the second medical group was in Scotland, there was no question of it ever being a branch of anything in London, and so a cellular structure emerged.²³ On the same railway ticket when the Edinburgh Medical Group was set up in 1967, I also set up the Newcastle Medical Group. The first four medical groups – London, Edinburgh, Newcastle and Sheffield – were all run by university chaplains, again the only bush telegraph I had. But it became quite clear that this had to be a secular exercise, to be seen to be independent, to be non-partisan, and to be independent of all lobbies. Subsequently, the medical groups – and there are people here, as well, today who were involved in setting up, for instance, the Bristol Medical Group [Dr Peter Wilkinson] – were all run by junior doctors, SHOs, but usually registrars, I should think, and we got the clergy out of our hair. Professor Sir Stanley Peart from St Mary's used to say that the greatest objection to the LMG is Father Shotter. I said, 'If you say that again and in public, we shall have you on our governing body'. And he did, and he was. The LMG could not have happened without that kind of critical support.

Max Rosenheim was brought on to the governing body because we thought Lord Amulree was getting too old.²⁴ Rosenheim is reported to have said at a meeting of the Royal College of Physicians, when the LMG was referred to as a religious body: 'I am on its Governing Body, so it can't be'. But it did take some time to differentiate the popular vision that because a chaplain was running it, it was a chaplaincy exercise. It wasn't.

Briefly, the method was translated into other activities. A postgraduate advisory group was set up by former LMG student reps to see whether we could do something at postgraduate level, and that led to the formation of the Society

²³ See Appendix 1, page 85.

²⁴ See biographical note on page 187.



Figure 2: Lord Amulree and Dr [now Professor] Alastair Campbell at the launch of the *Journal of Medical Ethics* in 1975. See Appendix 1, pages 98–101.

for the Study of Medical Ethics (SSME) – renamed the Institute of Medical Ethics (IME) in 1984 – which led to a publication called *Documentation in Medical Ethics*, a collection of offprints and reprints and the occasional original article, sold with membership. This was replaced in 1975 by the *Journal of Medical Ethics (JME)*, which subsumed the membership of the society into the subscribers to the journal.

Lock: I think I am going to pause you there, because we must go on obviously into the development, but what I would like to do is to concentrate on the early days. And I wonder if we have got any people who were students at the time and went to the LMGs and whether they could share with us their impressions about what it was like.

Dr Peter Wilkinson: I was a clinical student at King’s from 1967 to 1970 and I got involved with the LMG in the early days, because it had some very good lectures in my first term there and that was the draw. I subsequently got involved and was the student president in 1968/9, following Roger Higgs – who is also here – he was a year ahead of me.²⁵ I suppose I could say that, on a personal basis, the excitement of it was that it dealt with real issues. Students

²⁵ Two Presidents of the LMG attended the Witness Seminar: Roger Higgs, the fourth President of the LMG in 1967/8 and Peter Wilkinson, the fifth, in 1968/9.

tend to feel passionately about things anyway, before they reach more mature years, and the issues were igniting the interest and enthusiasm of the students, who were generating much of the desire to learn. And, of course, this was also a time of great change; for example, the Abortion Act of 1967 was a milestone that caused a lot of controversy.²⁶ The other thing I found, and again perhaps it was a personal thing, was that getting involved with the office that Ted [Shotter] ran equipped me personally with a lot of skills that I have been able to use subsequently – how to run meetings, how to set things up, a number of tips and hints, good ways of working and how one can make things happen – all that came from Ted. And I actually took this lesson after qualifying on to Bristol and we got the Bristol Medical Group going there, as Ted has mentioned. I might just say that the key to that success was finding one or two enthusiastic consultants. The person who really made it happen in Bristol at a senior level was Dr Ian Bailey, a consultant physician at Southmead Hospital, Bristol.

Lock: I think we want to go on to the periphery, if I can call them that, I certainly want to hear from Professor Boyd about the experience in Edinburgh and also Newcastle. But I just wondered if we could stick with London perhaps for another couple of minutes.

Dr Richard Nicholson: I was involved with the LMG from 1971 onwards, and I found it incredibly interesting, because many of the subjects that were being discussed were simply not covered in the general medical syllabus. So, for somebody who was going to go on to do paediatrics, the first time I came across child abuse was in lectures by Dr Christine Cooper from Newcastle, and other subjects also.²⁷ In particular, one had an opportunity, through the LMG, to visit St Christopher's Hospice and to learn about pain relief and palliative care.²⁸ That stood me in very good stead when I was a houseman. The constant discussion on informed consent led to a bizarre situation when I was an SHO in psychiatry of having to sit my consultants down to give them a seminar on informed consent, because during my first turn on the electroconvulsive therapy (ECT) rota, I discovered that not a single patient had given any form of consent at all. So, it [LMG] was of a practical value to a junior doctor after qualifying.

²⁶ See Glossary, page 193.

²⁷ Kempe *et al.* (eds) (1980); Cooper (1982).

²⁸ For further details on the hospice movement and the treatment of pain, see Reynolds and Tansey (eds) (2004).

Lock: Professor Roger Higgs, you were around at the time as well?

Professor Roger Higgs: I can confirm Ted’s extraordinary influence, but also I think that many of us felt that there were several pieces missing in medical education. Certainly, this is true for those of us who had come from other universities, and for those who had come through London as well. I think we were very aware of the narrowness of the educational curriculum in medicine. Which actually meant that when we talked about what the LMG tackled, it was not what we would consider conventionally now to be necessarily ethical subjects; they were subjects where there was some feeling of disturbance, I think, when our elders and betters hadn’t really grasped it. So much so – I am sure many of us will tell similar anecdotes – I certainly remember raising the idea of an ethics discussion as a postgraduate at the Whittington Hospital, and one of my consultants said, ‘Higgs, when I hear the word “ethics”, I reach for my golf clubs’. I think he was consciously echoing a Nazi phrase to tease me, but it was very clear that the generation above us were not only *not* offering ethics as part of our education, but also not particularly wanting any discussion of ethical issues at all.²⁹

Ted was told by one senior medic that: ‘these are things that should be discussed by consultants, with consultants, and in camera’.³⁰ And so for us, there was a feeling of an opening up, of a revolution, which, I have to say, linked with other revolutionary processes in British life at the time, whether it was Carnaby Street [London], sexual liberation, or whatever. But I think we were of a feeling of being somewhat on the crest of a wave.

²⁹ Professor Roger Higgs wrote: ‘When I was a medical student, our only official instruction in medical ethics was one lecture (in 1968) on etiquette, at which we were introduced to the rule of As (“no abortion, advertising, alcoholism, association with unlicensed practitioners” etc.) [Boyd *et al.* (eds) (1997): 1]. Thus it does need to be said that the medical groups were vital catalysts, but not the only forces to produce modern medical ethics education. Other forces included: the rekindling of interest in applied ethics amongst academic philosophers; joint writing/teaching by clinicians and philosophers; the *JME* and its linkages; close examination and discussion of key clinical “ethical problem cases”; health care innovations (such as the Lambeth Community Care Centre, an inpatient unit specifically set up to allow patients as near as possible the range of choice they enjoyed at home); and changes in attitudes both in the general public and amongst clinicians, especially those involved in medical education (particularly in general practice), all fuelled by at times quite passionate debate in the media. I had the privilege of being involved in much of the above and describe some of it in *The Healing Environment* [Kirklin and Richardson (2003): 179–206]. In the UK at least the postwar waning of the command/control approach to public services, changes in personal relationships and the democratization of health service decision-making at all levels joined alterations in the law to create the background to what is described in these pages.’ E-mail to Mrs Lois Reynolds, 19 August 2007.

³⁰ See Appendix 1, page 77.

Lock: Would anybody else in London at the time like to share their experiences? Does anybody have any questions or comments?

Dr Brian Payne: I was around at about the same time as Roger Higgs and Peter Wilkinson, and I was recruited by Ted to be the Student Secretary of the LMG in, I think, 1969 and did that job for about a year. I think a lot of what people have said is true. I'd come down from Cambridge, having been regarded there, as a sort of well-educated adult, and suddenly found myself in a London medical school, as pretty much the lowest form of life. And it was a time of great change. I can remember a seminar at the Middlesex on the cannabis report, where Lady Wootton came.³¹ I took a great part in the organization, and discussion around that meeting. And it really did enable us to take part in our own education in a way that our seniors had no conception of.



Figure 3: Sir Douglas Ranger, Dean of the Middlesex Hospital Medical School, at the 18th Annual Conference, 'The Creative Urge', held at the Royal College of Surgeons, February 1981.

³¹ Home Office (1968). Chaired by Baroness Wootton of Abinger Common (1897–1988).

Lock: Ted, I wonder if I could ask, somewhere it is mentioned that the public was allowed to these meetings. Was that true initially, or were they always there? And did they come? And how did they get to know about it?

Shotter: Certainly. Primarily, we addressed clinical medical students and student nurses. But we also said that the LMG was open to others and at various times we tried to define ‘others’.³² But, LMG lectures and symposia were always open to the public.

We advertised the LMG programme widely, by circulating each October, in the medical schools and teaching hospitals, some 15 000 or 16 000 copies of the lecture list (examples of which you have before you), reprinting it as necessary, usually in January. So, that’s a lot of bits of paper, for which we got a pretty minimal return, I might say. We are talking about 25 000 copies to produce an average attendance of pushing 100 per event. There were also individual posters displayed widely in the hospitals by the LMG reps, but because the LMG had no membership, it was the only way to produce an audience. The success of the LMG lectures or symposia stood or fell by the apposite topic and the reputation of the speakers.

There were a few occasions in some hospitals when LMG posters were removed by administrators on the grounds that children shouldn’t see this sort of stuff. If my memory serves me correctly, Anthony Bloom’s popular lecture on Preparation for Death at the Royal Free was a case in point. But administrators were by no means all hostile: the 250 people arriving at the London Hospital for the February 1969 annual conference, on ‘The New Poor’, were greeted with mugs of piping hot soup, provided free (and without prior arrangement) by the House Governor.

But, yes, we addressed ourselves to the public as well. There the public took part in the discussion. I should say that every single LMG symposium lasted for an hour and fifteen minutes, of which the last half hour was always for discussion.

Lock: I wonder now if we could move on to the early spread and whether Kenneth Boyd could tell us about the Edinburgh experience.

Professor Kenneth Boyd: I think there are probably two ways of telling the story: the first, as Ted has already indicated, is that there were a lot of personal

³² The Very Revd Edward Shotter wrote: ‘Students of other disciplines, such as social work, nursing and allied professions’. Note on draft transcript, 28 June 2007.

contacts. Ted and I both worked for the SCM in Edinburgh. I worked with Alastair Campbell, sitting behind me today, who was a chaplain at that time. Our senior people, we knew, were very supportive: James Blackie was Professor of Christian Ethics, and Archie Duncan, later one of the editors of the *Dictionary of Medical Ethics*, was the Executive Dean of Medicine at Edinburgh and saw a need for what was not yet within the curriculum at that time.³³ When Ted arrived and told the London story, we decided that we should try this out in Edinburgh. Alastair and I became the joint secretaries and we got support from the highest level in the university. And one of the reasons, I think, we got that support, was the other side of the story, which is that there was something going on culturally, and people have indicated a little about it. It was something to do with being not just post-Nuremberg [1947], but also post-Hiroshima [1945]. It had to do with all the new issues arising, and in fact before the medical groups began, some people may remember there was an organization, I can't remember its exact title, I think it was the British Society for Social Responsibility in Science.³⁴ There was quite a lot of feeling around, not just in medicine, but in science also. And as people have indicated, in the early days of the medical groups, in Edinburgh and other places, as in London, it wasn't just medical ethics, it was a broad range of issues.³⁵ We had symposia on topics like homosexuality and abortion, which were subject to legislation at the time, and on large issues to do with health and the environment, at which the Duke of Edinburgh, who became our patron, spoke to the Edinburgh Medical Group.

But I think the turn that it took in Edinburgh was that we wanted to look at some of the issues in greater depth, and we wanted to look at its effect on medical education. And so, with support from the Leverhulme Trust and the Nuffield Provincial Hospitals Trust, as it then was, we set up a project that did consensus-group type research, similar in some ways to what Richard Nicholson had been doing in his important work on ethics and research with children.³⁶ We looked at quite a variety of topics in that area, but at the same time tried to see in a series of experiments how we could put medical ethics into the curriculum and we had very receptive collaboration from a wide variety of departments,

³³ Duncan *et al.* (eds) (1977).

³⁴ The British Society for Social Responsibility in Science was established in 1969, with Professor Maurice Wilkins as founding President. See Burhop (1971); Dickson (1971). See also Rose and Rose (1969); Pirani (1970); Werskey (1971).

³⁵ Boyd *et al.* (1978a and b).

³⁶ See, for example, Nicholson (ed.) (1986).



Figure 4: The Revd Professor G R Dunstan, the Revd Dr Mary Seller and Professor Norman Morris at the 18th Annual Conference on 'The Creative Urge', held at the Royal College of Surgeons, February 1981.

some of which really you can find traces of today in the medical curriculum, and that was before the Pond Report.³⁷ It was partly our experience with that that encouraged us to go ahead and have the Pond Inquiry. I am also reminded – because David Morton is sitting next to me – that the Institute of Medical Ethics went on to have, following the Edinburgh experiment, a working party on the use of animals in medical research, chaired by Gordon Dunstan, and that was quite a good example of the kind of research that we were doing.³⁸ And in fact, still perpetuated today, because as a result we have an ongoing national group that looks at these issues, which is one offshoot really of the kind of research we were doing.³⁹ I gather that someone will talk about Pond later, but that was another development that took place at that time.

Lock: Any comments or questions for Professor Boyd? Do we have somebody from Newcastle here? Yes, Bryan Vernon. The Newcastle Group was formed in the same year as Edinburgh [1967], wasn't it?

³⁷ Boyd (ed.) (1987). Sir Desmond Pond, Chairman.

³⁸ Smith and Boyd (eds) (1991).

³⁹ The Boyd Group was founded in 1992 as a forum for open exchange of views on issues related to the use of animals in science, and whose name is taken from its Chairman, Professor Kenneth Boyd. For further details see www.boyd-group.demon.co.uk/about_us.pdf (visited 20 June 2007).

The Revd Bryan Vernon: The Newcastle Medical Group was there then [1967], but I wasn't. I wasn't involved until about 12 years afterwards, so it may be premature to make comments, and you may want to go on to somebody else.

Lock: Is there anybody else from Newcastle here?

Vernon: Not currently from Newcastle. Nobody older than me is here from that area, I think. I got involved in about 1979, soon after going to see the Dean, to say it would be quite interesting to engage a bit with medical ethics within the medical school. His view was that I should go off and talk to the Christian Medical Fellowship about this, as being the way into ethics. This was someone who has had, I must say, quite a kind of Damascus Road experience with medical ethics, because it was Lord Walton.⁴⁰ So it's quite interesting that there's been that considerable change. Just as other things have been going on during the time. We had slightly different forms of meetings from the ones that Ted [Shotter] was talking about, maybe because we were a smaller, discrete unit, without the benefit of the whole of the London medical schools. And various memories that I have of that are that we organized our meetings so that there was always catering afterwards, and we were seen as the group where people never got anything like as drunk as they did at MedSoc [Medical Society] on a Friday night. So this was the more intellectual group who did some thinking, at least before they ever did any drinking.

Lock: And that didn't put them off?

Vernon: No, it certainly didn't put them off. And it gave us a sense of anxiety – I think Ted has slightly hinted at this – that there was always the possibility that the group was going to be taken over either by Christian fundamentalists, or by people with some particular Marxist or leftist-leaning ideology, who might have hijacked the whole thing. One other thing: one feature of our programme was that we usually had something or other on alternative or complementary medicine at some point, during the year. We were certainly very much open to the public, and I used to say in our later years, that we used to have odd members of the public who used to come, and I have to say that was also one of the strains in terms of the medical group that there are one or two people,

⁴⁰ The Revd Bryan Vernon wrote: 'When I arrived at Newcastle University as a new chaplain in 1979, I had a meeting with Professor Walton (as he then was) to ask about ethics teaching in the Medical School. At that stage he was content that this was a voluntary activity. Since then, he and many other members of the profession have come to see the importance of embedding the subject in the curriculum'. E-mail to Mrs Lois Reynolds, 8 August 2007.

certainly in Newcastle, and maybe in other centres, who tend to come to public lectures, or anything else that is going on, and make their presence felt.

Lock: Now has anybody else got any other impressions of other groups they would like to tell us about?

Higgs: I just wanted us also to mention the conferences, which were very important, because they were organized on a year-by-year basis, with even more student input, I think, than the rolling programme, which sometimes just carried on from year to year, like Cicely Saunders' wonderful lectures, which were an obvious great draw.⁴¹

Lock: These were only in London were they?

Higgs: Certainly conferences were run by the LMG, but from what I remember I get the impression that these also drew people from other parts of the country. Also what I wanted to say was that there was an international dimension to a lot of the discussion in the conferences, which was another thing that was missing, certainly in my medical education.⁴²

Sir Malcolm Macnaughton: I would like to mention about what happened in Aberdeen in the later 1950s when Sir Dugald Baird was in the Chair of Obstetrics and Gynaecology, and had been doing abortions in Scotland for the previous ten years without any trouble, because the law in Scotland was different. If a mother, or a woman and her daughter thought that an abortion was necessary, they could go ahead and do it. Whereas in England that was not the case, because the Procurator, or whatever his equivalent was, could step in and say 'No'. So, from the late 1930s Dugald was doing abortions in Scotland.⁴³ When I went to Aberdeen as a lecturer in 1955, I started doing abortions then too, and continued right up until my retirement. During that time the medical students always had a session on abortion and the ethics of it, so from the late 1950s there were medical students in Aberdeen who were getting some introduction to ethics. I feel a lot of the ethical things have been driven by the issues.

⁴¹ See Appendix 1, pages 76–9. The first conference was held on 14–15 February 1964 at Student Movement House, 103 Gower Street, London, WC1, where four seminars were arranged on human relations, preparation for death, neurosis and Christian belief and medical ethics. The speakers included Archbishop Anthony of Sourozh; Dr Helen Hudson, Tutor to Women Students at King's College, and a member of the Community of the Resurrection, at a cost of 5s [25p].

⁴² See, for example, Appendix 4, pages 127–30. See also Jones *et al.* (2001).

⁴³ Baird (1975). For a more detailed legal history of abortion in Scotland, see Davis and Davidson (2006).



Figure 5: Tim Helme, LMG President 1975/6 and Convenor, leading Dr Colin Murray Parkes to open the 13th Annual Conference, 'Death: The conspiracy of silence', held at the Middlesex Hospital Medical School, February 1976.



Figure 6: Dr Tom Oppé (1925–2007), Dr Cicely Saunders (1918–2004) and Prebendary Edward Shotton at the 15th Annual Conference on 'Pain: A Necessity?', held at the Charing Cross Hospital Medical School, February 1978.

The issues come first and then people start thinking: ‘Now, what are the ethics of this?’

Lock: Very valuable.

Dr Ian Tait: I remember that in the early 1970s Bernard Reiss in Cambridge started what he called ‘interest groups’.⁴⁴ He got some of his fellow general practitioners to allow preclinical medical students to visit and talk to some of their patients at home. In those days Cambridge had no clinical school and very much thought of itself as a fundamental science department. Reiss would get students who were interested to go to meet patients of his fellow GPs. It wasn’t to watch the doctor working, but to get alongside the patients and to look at their experience of being ill and what it was like. These visits were then the subject of a weekly discussion group lead by Dr Reiss, which nearly always came up with what were broadly ethical or behavioural interests and worries. Bernard Reiss is dead now, but he was a great initiator and I would like that to be known.⁴⁵

Fr Brendan Callaghan: I was involved with the Glasgow Medical Group initially, and got dragged further in after that, but the initial involvement was with Glasgow. Prior to that, as a rather superannuated undergraduate in Oxford, I talked my way into a graduate seminar, which brought together moral philosophers and medical students, and I found it very interesting, being neither at the time, to listen to these two groups talk past each other with great erudition, despite the very skilled and highly qualified professorial leadership that was being provided.

Two issues from Glasgow come to mind. The first is that ‘talking past’ didn’t happen, what was being discussed was understandable, even to a lowly clinical psychologist, let alone anyone else. But also having one or two members of the faculty who were committed to the whole enterprise – and who, I think, had been recruited or suborned (or whatever is the appropriate verb) by Ted – was crucial. There was almost a guaranteed student interest, the topics came from the students, but there had to be somebody a bit further up the ladder to provide an anchor, and also respectability and access to places, spaces, within the university.

Lock: What year was this?

⁴⁴ For example, Coni *et al.* (1986).

⁴⁵ See biographical note on page 186.



Figure 7: Professor John Marshall speaking to the President of the LMG, Patrick Magee (Westminster), at the pre-conference dinner and briefing of speakers for the 18th Annual Conference, 'The Creative Urge', held at the Royal College of Surgeons, London, February 1981.

Callaghan: That would be somewhere between 1975 and 1976, the second or third year of the Glasgow group. We graduated to Letraset for doing the front of the programme.⁴⁶

Shotter: May I come back to the method? I think that the LMG method, the medical group method – was first described as such by Kenneth Boyd, which I reiterate, was students identifying topics through a representative council and consultative multidisciplinary council of advisers identifying the speakers. Because of the confusion as to what medical ethics might be, at no point did we say that we were teaching medical ethics, or even learning about medical ethics. We eventually produced a byline to the LMG, which was 'a student group for the study of issues raised by the practice of medicine which concern other disciplines'.⁴⁷ And the thinking behind that was that with medicine, not being practised in a vacuum, there are other disciplines within the university which may well have thought about some of these issues. We named them as moral

⁴⁶ Letraset, an art supplies manufacturer, was founded in London in 1959 selling instant dry transfer lettering from 1960, 'a breakthrough in typography'. See www.letraset.com/shopcontent.asp?type=aboutus&cssctn=default (visited 15 May 2007).

⁴⁷ See Appendix 1, note 187.

philosophy (ethics), moral theology (ethics), law, and initially we said sociology, but thought better of that and used ‘the social sciences’ in the end, because we weren’t sure what sociology was either.

Professor Alastair Campbell: As Ken has already mentioned, I was the other joint secretary of the Edinburgh medical group and eventually the editor of the *Journal of Medical Ethics*, but we may be coming to that later. Ted’s comments remind me of the state of philosophy in that period, and as a philosophy graduate, graduating in philosophy just at the end of the 1950s, it really was not thought to be a proper thing to do, to discuss practical issues. And this was clearly letting philosophy down badly, if you had come up with some practical conclusion from anything at all that you were doing in philosophy. And I think one of the interesting things that the medical groups did was to begin to pull in philosophers who did have an interest in relating, not an oversimplified, but a properly rigorous philosophy to the kind of dilemmas that were being thrown up by medicine. And one person, who I know sent his apologies today, but who’s a very important early figure is Robin Downie, the Professor of Moral Philosophy in Glasgow university, working with Ken Calman and other medical colleagues from an early stage in trying to show that you could relate philosophy to practical problems in a way that was appropriate and helpful.⁴⁸ The great strength I think of the medical group approach was that it was always insisting on staying first in clinical reality, it was never going to be a mere talking shop, it was always going to keep its feet somewhere firmly in clinical medicine, and I think this has reaped great benefits and contrasts quite a lot with some other developments later, which perhaps are very interesting in clinical discussion, but seem to lose track of what is happening in clinical medicine itself.

Lock: I would like to move slightly further on now and talk about developments elsewhere, because obviously we are principally concerned with the situation in this country, but there were developments happening, partly as we heard in the US, but particularly in Europe. And we are very fortunate to have Povl Riis from Copenhagen here and we will ask him to tell us about the Danish experiences, why it started, when it started, what was done and how it progressed.

Professor Povl Riis: Thank you for inviting me. It has been a pleasure to accept the invitation. I will start by showing the structure that I will use for this brief presentation, and I use the modern version: the microlevel, where we meet students, patients, relatives and co-citizens when we are professional; and the

⁴⁸ This is the subject of ongoing debate. For example, see Cowley (2006).

mesolevel [mid-level, between macro- and micro-] where the administrators and the local politicians, are situated, then the macrolevel, where we have our parliaments and part of the ministries. I have added a new term, supra-macrolevel [global level], from where the immaterial values come and they constitute a kind of a growth Cambrian layer for new legislation or revision of old legislation.⁴⁹

When I return to the time when the interest in ethics started in Denmark and in the other Nordic countries, I would say there were not very many, it started as individuals. We met the ethical problems when we met the patients and, we had brought something from the Second World War. My father's younger brother, a vicar, was severely tortured, but survived three German concentration camps. My father was involved with the underground, another uncle received the weapons that the Royal Air Force dropped to the Danish resistance movement, and I was in a military group, partly underground. The best thing I can say about my non-hero position was that I learnt that courage is a way of controlling one's anxiety. We took these experiences with us, and I heard from the concentration camps about the experiments on prisoners, learnt that it took place in the gulags and Japanese prisoner of war camps, and this knowledge was there when I was a young doctor in 1952, and still it was a motivation for changes. Do not just say 'never again' after the 1930s and the 1940s, and the Third Reich, but also say: 'Is it now time for creating a new society without being a fascist or a communist?' This motivation created a need for a new language, a new structure, a terminology, and by thinking about: 'What is research?' 'What are the rights of the citizens, the patients?' How should we analyse an ethical dilemma in order not to work in the future only with casuistic stories and narratives, but create something that can be applied for analyses on the clinical microlevel?

And we did that, and, I hate to admit it, but it's the truth, we didn't start with Plato, Aristotle or Kant, we got help from historians, later on philosophers, so I am a bit better prepared today, but it started from the bottom at that time.

Then because we had found our terminology by ourselves, we still were situated at the clinical and scientific microlevel – I will save you from my definition of ethics, it's very long, and can only do with a couple of extra respirations when I mention it. But we did it, and then started in the late 1950s. Fritz Fuchs, a Danish obstetrician, and I discovered a way of performing amniocentesis and antenatal sex determination. I cannot remember what we told these women

⁴⁹ See, for example, Gould (1989).

from haemophilic families in detail, that we would put a needle in their womb and see if we could get something useful out, but afterwards I sat overnight at the microscope to see if there were cells with a sex chromatin. In the first publication we at least mentioned that there were ethical problems related to this, that we would not select only female fetuses for survival when the antenatal method of diagnosis later would be applied generally – the opposite of killing them just because of their sex, which is being done today in some countries.⁵⁰

When I became a young administrative physician-in-chief of a medical university department in 1963, I started lecturing for the students and the young doctors in the department, and slowly the ethical discussions spread to other institutions. It was not formalized, still at the bottom levels, not macrolevel, touching the part of mesolevel, but unofficially. And then we moved on further.

I contacted the Norwegians and the Swedes. In Sweden it was Clarence Blomquist, the psychiatrist who unfortunately died very young of a malignant brain tumour, and Erik Enger, Professor of Nephrology in the University of Oslo, still alive.⁵¹ In the early 1970s, we were asked by the medical associations of the three Nordic countries – Sweden, Norway and Denmark – to revise the First Helsinki Declaration, because it was still not being used by clinical scientists and there were parts of it that reflected that it was made by medical associations and not by many others who were also active in health science research.

We dealt with the triangle that is still there – scientism (the interests of scientists, the freedom of science); legalism (the judicial aspects) and societism (which still is a challenge to the World Medical Association (WMA)). I am rather indiscreet here, but it is the case. The three of us wrote the second version and soon after the Nordic universities and medical associations began to be interested in research ethics, and Denmark created a national research ethics committee system in the latter half of the 1970s.⁵²

Then it appeared that we missed the overall societal perspective. I remember asking myself: ‘Why do we create codes, have established committees, and train students and young doctors in research ethics, when common patients

⁵⁰ Fuchs and Riis (1956).

⁵¹ Blomquist (1962, 1963, 1965, 1973); Enger and Hodne (1986); Enger (1999).

⁵² World Medical Association (WMA) (1975); Shephard (1976). See also Blomquist *et al.* (1975). Note the changes introduced in the 1975 revision to the Declaration of Helsinki. See Glossary, pages 202 and 194.

and relatives don't have the same right to be informed of what is planned and to be asked if they accept it?' These questions were reflected in a new national movement, and later on, a global perspective.⁵³

We saw the phenomenon of 'research ethics' exported and waited for the import of the solutions. Several European countries did the same. We learnt that we ought not to go for systems or lectures that were formed as a kind of cookbook, because science is moving, the national cultures are moving, so you have to rely on fundamental immaterial values, and have them ready to project into new situations.

We made mistakes and I will end by mentioning them. We were too late to find out that there was a hegemony of medical doctors, at least in research ethics, but also concerning problems dealing with patients outside research situations. Again, the WMA was too fond of the part of the Hippocratic Oath that said: 'My colleagues are my brothers'. Sometime, I would have preferred another formulation that said: 'Patients and their relatives are my brothers and sisters'. This was one of our delays in the development of teaching ethics.

The second one was the dominance of the clinical randomized-controlled trial (RCT). It's an extremely necessary and important form of methodology, but not a sufficient part. Johannes Fibiger, a Dane, published in 1898 one of the first trials, but it was Sir Austin Bradford Hill, who opened the world's eyes with the streptomycin trial in 1948.⁵⁴ But rather too late we found out that the methods of diagnostics also has to be included, also prevention in epidemiology and that we should give up speaking of medical ethics, and instead of health science and health system ethics, including as we did nurses, midwives, psychotherapists, physiotherapists, and ergotherapists [the European title of occupational therapists], pharmacists, and many others around the patient, which means that you can end up by having one system, and one common ethical education that we present today, with many other disciplines. The two latest problems that I will mention are the too-late inclusion of researchers' ethics. Some of us used such cases in lecturing, but started by thinking: 'It's scientific fraud'; 'It's for a minority'. Now I prefer to speak of research and ethics, and to include the grey zone, where you behave decently and honestly in many other aspects. Despite the increasing attention of scientific honesty and dishonesty, it still needs some

⁵³ Riis *et al.* (1980).

⁵⁴ For background details of the streptomycin trial, see Tansey and Reynolds (eds) (2000). See also Hrobjartsson *et al.* (1998).

time for researchers' ethics to be a common part of ethics related to patients and citizens.⁵⁵

And, the last thing is the absolute dominance of the informed consent. Again, extremely valuable, but we have to include in research: (1) children, as Richard Nicholson and I have worked a bit together on; we have (2) demented patients, and we have an even more important group in Europe and around the world of (3) acute, disastrous events in citizens' lives, heart patients, and unconscious patients. Research using such patients and the ethical conditions applying to them have been changed by the European Union (EU), so that we now call their own doctor and a representative of the family in order to get an informed consent. We have four and half minutes as a temporary window for doing something for some of these patients before they lose their brain capacity or their lives. So, there's still much to do. Therefore I think history – where we learn from what we have done, what we could have done better, and all the challenges that are still there – is so important.

Lock: Thank you very much. How do you introduce all these concepts to students? Are they done as situational ethics?

Riis: Yes, I like the mixture of that, they know the language and know how to get to the core of the ethical constituent of a problem and then we teach them how one should consider this. Not tell them always what to do – I love the educational principle of being a kind of eye-opener or brain-opener for them to bring it in and they have been very fond of that, and now we have it very formalized in all universities.⁵⁶

Lock: Questions or comments for Povl? I think this takes us logically into the US and I know that Michael was in nappies at the time. He does know the literature very well and perhaps you could just tell us a little about the evolution and then I would like to go to people like Kenneth Boyd, Ted Shotter and Ian Tait, who went to the US and observed what or what was not going on in the ethics field.

Barr: I don't know a lot about the evolution of the teaching of ethics in the US. I do know that there is a long tradition of mutual influence between British and US medical ethics. Of course, Thomas Percival devised guidelines for the

⁵⁵ Concerning the privacy of case studies and their confidentiality in journals, see Rogers and Draper (2003).

⁵⁶ See, for example, Riis *et al.* (1980).

Manchester Infirmary in this country at the end of the eighteenth century, and even though that may have had a limited impact in the UK, it had quite a large influence on American medical ethics and the first code of the American Medical Association (AMA) in 1847.⁵⁷ Within medical ethics teaching I think things had been perhaps slightly behind this country, although I don't know. I would be very interested, frankly, at this point to turn straight back to Ted or someone who went to the US during that time.

Lock: You went three years, I think, after the start of the group, Ted, didn't you?

Shotter: Yes. In 1966 when I was trying to fund the LMG, which was run on soft funds, one of the first grants I got turned out to be a Wemyss Foundation scholarship, that's a DuPont body, which paid for me to visit American medical centres. I went from frontier to frontier but not from coast to coast. I certainly didn't get to Boston, because no-one ever replied to a letter. But what I found in Chicago and in Birmingham, Alabama, was the involvement of clergy, sometimes medically qualified clergy, but not in medical ethics, it was pastoral care of junior doctors mainly I found in Chicago, and I could not find any programme in medical ethics. In Houston, Texas, I saw [Michael] DeBakey, [the Texan cardiac surgeon] in his white coat, walking across the grass with all his acolytes, but I could find no programme in medical ethics. There was something there called the Institute of Religion, but they weren't interested in ethics either.⁵⁸

Lock: Kenneth Boyd, was this your experience as well?

Boyd: I had the experience mainly of the institutes like the Hastings, and the Park Ridge institute in Chicago, but that was a little later, a good ten years later, than Ted.⁵⁹ My impression from talking to Americans is that while there was quite a lot of ethics taught in premedical courses, there wasn't so much in medical schools. In fact only about five years ago I had a communication from somebody, in one of the leading American medical schools, who was just starting setting something up, so I think the picture was much more patchy.

⁵⁷ Baker *et al.* (eds) (1999).

⁵⁸ The Institute of Religion was founded at the Texas Medical Center (TMC) in Houston, Texas, in 1955.

⁵⁹ See note 6. The Park Ridge Center for the Study of Health, Faith, and Ethics is an independent, non-profit, non-sectarian organization affiliated with Advocate Health Care at Park Ridge, Illinois.

And it raises for me a much wider issue about who leads what we are going to call medical ethics, or bioethics, because in the US there is a big industry for philosophers and also for clinical ethicists. In this country it has tended after the rise and demise of medical groups to be led very much by law. Perhaps it's simply that training lawyers to sue doctors is a more lucrative thing to do, and medicine hasn't caught up. And of course, as Alastair would say too, nursing has taken a lead, there's a big industry in nursing. But the question I just want to raise is how far that affects the kind of ethics you do, and my suspicion is that the kind that the medical groups started off with was best suited for medical schools, but there were many other things going on, with similar names, but different kinds of activity.

Lock: Ian Tait, you went to the US a number of times?

Tait: Yes. In 1971 I went to look at the teaching of behavioural sciences in US medical schools on a Nuffield Travelling Fellowship.⁶⁰ It was patchy, of course, but you tended to go to the places that you already knew had something interesting to offer. There were some very exciting things going on. My overwhelming impression, however, was that the medical students in the preclinical period were extremely ethically aware and lively, but it was knocked out of them when they started their clinical course, where the aim was to train them to be clinically competent interns. Any discussion of ethics, or moral issues, was not encouraged. I felt that in the medical school, with its extremely complex and interrelated organizations, any kind of change in one part upset the other parts of the medical school, and that although there were some wonderful ideas, there was still a huge job to do. It is essential that senior clinicians respect and reinforce the ethical teaching of non-clinical departments if it is to be effective.

Professor Donna Dickenson: When I was chairing the Open University 'Death and Dying' course in the early 1990s, I was in touch quite frequently with a large programme that was being mounted jointly by the Hastings Center – which was founded, let's remember, in 1969, so it does go back.⁶¹ Of course, the report as well is of the same vintage. The programme was founded jointly by the Hastings Center and the Educational Development Corporation in Boston, much maligned Boston. I went to university there, so I think they do occasionally

⁶⁰ Tait (1973).

⁶¹ The Hastings Center was originally known as the Institute of Society, Ethics and the Life Sciences. See Ramsey (1974). See current OU course content at www3.open.ac.uk/courses/bin/p12.dll?C01K260#op1 (visited 10 January 2007). See also note 6.

write back. In any case, that was an extremely comprehensive programme which went into something like 300 hospitals to do post-qualification training for doctors and nurses and I thought it was very interesting from the Open University viewpoint, because it was bottom-up. It used a questionnaire, which was administered at the very start of the programme, and it was very practice-based, mainly on issues to do with death and dying, and you found out what people's initial reactions were and then you went to work on those, treating them critically. So although I agree that there is a rather positivistic slant in general in US medical nursing ethics education, I think I would be a little more optimistic about how wide the spectrum has become. At least by that period, I found this quite an impressive programme.

Lock: Do you know what the response rate was of the hospitals that were approached?

Dickenson: I think it was quite high, and it was compulsory for all their personnel, so the numbers trained were very large.

Lock: Does anybody else have any experience of this? Richard Nicholson, you were nodding your head vigorously. Did you experience the US at all?

Nicholson: My experiences in the US were rather later, so I think not relevant today.

Macnaughton: I just wanted to say something about one of the problems in the US, that the different states have different ideas, and it's very difficult to get anything [agreed] across the board. After the Warnock Committee in 1985, the College [Royal College of Obstetrics and Gynaecology] and the Medical Research Council (MRC) set up the Voluntary Licensing Authority, which was to try to regulate *in vitro* fertilization (IVF) until the Human Fertilization and Embryology Authority (HFEA) came in 1990.⁶² One very eminent American chap wrote to me and asked, 'How did you do this, and how do you do that?' I told him what we had done and he wrote back saying, 'We couldn't do that in the US, because the states would all have different ideas'.

⁶² The Human Fertilization and Embryology Authority (HFEA) is a statutory body, created in 1991 under the Human Fertilization and Embryology Act (1990). See Glossary, page 197. See also the Voluntary Licensing Authority for Human *in vitro* Fertilization and Embryology papers (GB 1538 C12, dated 1985/6) held at Royal College of Obstetricians and Gynaecologists. For the background to the British system of regulation of assisted reproduction, see www.publications.parliament.uk/pa/cm200405/cmsselect/cmsstech/7/704.htm (visited 9 August 2007).

Professor Raanan Gillon: As part of this IME organization, currently its Chairman, I've had a different and rather positive view of the US and medical ethics. I had a travel scholarship from the Royal College of Physicians in 1986 and for six weeks went dashing around the US, visiting different centres that taught medical ethics that had been identified by the Hastings Center as particularly good ones. I must say I was very impressed with the way they did things in the US, and got a lot of very useful lessons, which I subsequently published about things to do and to avoid when we did it in the UK.⁶³ These included practical things, like getting stuck into the power centres in medical schools, a tremendously important lesson to this day. Another important lesson was the need for a reasonable balance between practical issues and theoretical analyses of those issues, and there were lots of other useful ideas. So I think we have been getting a very negative view of American approaches to medical ethics, and I agree with Donna on this.

Lock: But you were, of course, quite late. It had become an industry almost in the US.

Gillon: The mid-1980s, I don't think I would call it late 1980s. But, yes, medical ethics teaching was widely spread in the US by then.

Tait: I think it's important to get our dates right. I first went to the US in 1971 and a lot happened between then and the 1980s. I went back to see friends, and went to two very encouraging and exciting meetings of ethical committees, where a range of hospital staff – nurses, physiotherapists, a solicitor and ethicist – had regular meetings where any clinician could bring a case where they were concerned over ethical issues. I was there when a doctor who was worried about the management of a case of terminal care came, and there was a very helpful discussion. So, I am sure good things happened between 1971 and 1985.

Lock: I think we could now move on to the developments in the parallel disciplines, because as I said in the introduction the parallel disciplines, such as nursing and dentistry, and animal research and so on, also had their problems about teaching ethics. Do we have a nursing representative? Well, we certainly have a dentist. Professor Gelbier, would you like to say something?

Professor Stanley Gelbier: Immediately after the Pond Report was published, I did a survey of all the Deans of dental schools in the UK and of all of the presidents of the student unions at the same time, and I was assured by all the

⁶³ Gillon (2004).

Deans who replied that they were ‘doing ethics’, that is, teaching ethics.⁶⁴ Most of the student union presidents said they had never heard of it and didn’t really know what I meant by ‘ethics’. I wrote a report, after which I was asked by the General Dental Council (GDC) for a copy. It started them off on a tangent, to decide eventually how to set a syllabus in ethics, which came out some time later. When I discussed this within my own dental school – I was teaching at King’s at the time – it was clear that the senior staff again thought they were teaching ethics. What they really meant was that if there was a discussion about whether a tooth comes out or not, or what sort of filling, they would mention what was right in their opinion, and therefore that was ethics. But there was no formal teaching. Together with a few colleagues I eventually started a small course at King’s, which later grew as we merged in 1998 with the United Medical and Dental Schools of Guy’s and St Thomas’ to form the Guy’s, King’s and St Thomas’ (GKT) Medical and Dental Schools of King’s College London. I was lucky that I could turn to medical colleagues. Roger Higgs is a good example of somebody being around that one could talk to and think about what we meant by ethics. But it was a hard grind getting it accepted. Now it is fully accepted. The GDC has it laid down in the Regulations, and all the dental schools have to do something. They have to have a formal course, and it’s recognized now that ethics needs to be included as part of everyday teaching at chairside as well as in lectures.

Lock: But nothing had happened before the Pond Report?

Gelbier: Nothing formal, no.

Lock: Professor Morton, could we hear the position about animal research?

Professor David Morton: Animal research has been fairly controversial for several centuries, interestingly enough, with some scientists disapproving of it and refusing to do it. I suppose, more recently, it was Singer’s book in 1975 on animal liberation that led the way to public debate on it.⁶⁵ That was followed by Tom Regan in 1983, where they came to the conclusion that animals should not be used in research, but from different perspectives.⁶⁶ I would say that at the present time, the intellectual debate has come from those opposed to animal research, as opposed to those defending it, so by far the great weight of literature is against, as opposed to in favour. We have seen recently in the UK, terrorist

⁶⁴ The survey was not published.

⁶⁵ Singer (1975). See also Rasko *et al.* (2006).

⁶⁶ Regan (1983).

tactics by animal rights groups, as opposed to the animal welfare groups. Where animal welfare has come in is the appointment of certain ethicists like the Revd Tony Birbeck MBE and Professor Stephen Clark to the Farm Animal Welfare Council, where they link animal welfare to avoiding harm.⁶⁷ So the Farm Animal Welfare Council deliberately encompassed an ethical dimension. But to come back to animal research, what has also been instigated in the late 1990s are ethics committees, to scrutinize at an institutional level, in addition to the Home Office inspectorate level, whether a particular research project should be carried out or not.

Lock: How does this all feed into teaching?

Morton: I would say that the teaching of biomedical ethics or animal ethics, in the undergraduate curriculum is really pretty poor, I don't think it occurs in many undergraduate courses at the moment, which is rather sad. There isn't a big push in that direction as far as I can see. Where it comes in is in medical ethics. Tom Beauchamp, who wrote the classic medical ethics textbook in the US with James Childress, says that 85 per cent of the sales of this book, *Principles of Bioethics*, are to non-medical courses in the arts faculties, and I suspect the same is true for animal ethics.⁶⁸ I think the debate is more in the arts, rather than in the sciences.⁶⁹

Tansey: May I ask a question, David? Do you think that the change in the 1986 legislation made a difference to teaching ethics or animal experimentation? I say this from my own personal experience. Being registered under the 1876 Act, I learnt by watching people do things. I never had any training; I never had to consider ethical issues. In the 1990s I found myself teaching on Home Office new licensee courses, which included lectures on ethics.

Morton: What came in with the 1986 Act was an increase in the scrutiny of the way in which research was carried out. It obviously had ethical overtones.

⁶⁷ For the December 2005 *RCVS Veterinary Nursing News*, see www.rcvs.org.uk/shared_asp_files/uploadedfiles/69CAF9E4-2F56-4E51-8902-3875436BC9E6_vn_news_dec05.pdf (visited 9 January 2007). See also Ministry of Agriculture, Fisheries and Food (MAFF) (1995) [The Banner Report]; MAFF, Farm Animal Welfare Council (1998); Home Office, Animal Procedures Committee (2001).

⁶⁸ Beauchamp and Childress (1979) introduced the key philosophical principles of beneficence (doing good); non-maleficence (always not doing harm); justice (treating patients fairly); and autonomy (control of treatment in patient's hands). See also Beauchamp (1994). For the Pond Report's review of these principles, see Boyd (ed.) (1987): 11–12.

⁶⁹ See, for example, Lederer (1995); McLean (ed.) (2006).

It wasn't until the late 1990s that it was compulsory for scientists to go on a course that taught ethics and even then, the ethics [taught] is still rather limited, to the Three Rs and not to the broader issue of about how animals are used by society.⁷⁰ In the early 1990s, the IME Working Party, chaired by Gordon Dunstan, resulted in a publication by Kenneth Boyd and Jane Smith on the use of animals in biomedical research.⁷¹ This was probably the first major publication in the UK on this issue, and I don't think there's been another since.

Boyd: The Nuffield Council on Bioethics has just produced a very good report, which David [Morton] and I were both involved with.⁷² In a sense if one's looking for the long-term outcome of the kind of research work needed, I think that is being done very well now by the Nuffield Council on Bioethics.

Just to go back, I was going to disagree slightly with David about teaching, because it seems to me that what some of us learnt about how to approach teaching in medical ethics from the clinical end – perhaps it is a rather highfalutin' way to call it a Socratic approach – but certainly not to talk at people, but to raise questions. That, in my experience, is a useful approach, also in Home Office courses, even though they are limited in terms of ethics.⁷³ This is one that colleagues and I have used in Scotland. You ask people to bring out their own feelings about the use of animals, and then you give them examples to study. In my experience, on the day that works very well. I don't know whether it affects any long-term changes in people's attitudes.

Morton: But, how widespread is that?

Dr Diana Manuel: I wonder if I might inject a historical perspective here on animal experimentation. My doctorate was in the history and philosophy of science and was devoted to Marshall Hall [1790–1857], who was an eminent

⁷⁰ Russell and Burch (1959) suggested that 'the humanest possible treatment of experimental animals, far from being an obstacle, is actually a prerequisite for successful animal experiment' [page 4], and proposed the Three Rs: Replacement, Reduction and Refinement.

⁷¹ Smith and Boyd (eds) (2002).

⁷² Nuffield Council on Bioethics (2005).

⁷³ 'All training programmes for applicants for personal and project licences...should be accredited under a scheme recognized by the Home Office. Accreditation seeks to achieve common and high standards for licensee training which will facilitate free movement of licensees within UK and Europe as well as ensuring high standards in the use of animals for scientific procedures....The Accreditations Scheme for training programmes for personnel working under the Animals (Scientific Procedures) Act 1986, operated by the Institute of Biology, is currently recognized for this purpose.' See www.archive.official-documents.co.uk/document/hoc/321/321-xf.htm (visited 9 January 2007).

physiologist and animal experimenter in the early nineteenth century. He was the principal object of the developing antivivisection movement in this country. Part of his aim was to establish physiology as the basis of a more scientific medical curriculum and to oust anatomy from its premier position. His experimental work on the nervous system was exceptional and concentrated particularly on the concept of reflex action. But the point that I want to emphasize, and that is relevant here, is that Hall – and William Paton from the Royal Society endorsed my paper on this – proposed a code of ethics in the 1830s for the use of animals in experimental work. Although Marshall Hall was a physiologist, he was anxious to have his work applied to medicine and he published his code of ethics in 1831 at the front of a small book on the circulation of the blood.⁷⁴ He also proposed the setting up of a physiological society, but neither of his proposals was implemented until after his death in 1857. But his code of ethics is worth paying attention to. He was informed by, and refers to, Percival's work on medical ethics.⁷⁵

Lock: Thank you very much. Very interesting. I think we could move on now to the postgraduate scene, because we have so far more or less been discussing undergraduate education and yet, as we heard from Ian Tait, as soon as you got qualified you were discouraged from ever having another ethical thought. And I think one of the things we need to explore is why was so little apparently done for the postgraduates, what were the medical royal colleges doing, we have a past president of one medical royal college here [Professor Sir Malcolm Macnaughton], and we could also look at the individual specialties. I would like to ask Tom Arie what education in ethics there was for psychiatrists?

Professor Tom Arie: I can't answer that terribly well. The short answer is, I think, that if psychiatrists don't have too much to boast about in this regard, they also have less to be ashamed of than some.

I don't know if this is the right point at which to talk about some of the provincial developments. I was intrigued by what happened in Nottingham, where I taught, a medical ethics group wasn't set up until 1989, well after the Pond Report, well after everything really, the last phase. And the reason that the group didn't happen sooner, although there had apparently been initiatives from students to do something, was that the Nottingham medical school took the view that being the first of the new medical schools – the first students

⁷⁴ Hall (1831).

⁷⁵ Percival (1803).

graduated in 1975 – we were different, and didn't need a para-curriculum, for all this was already embedded in our curriculum.⁷⁶ Well, it wasn't. And the students finally nudged us to do something. Now, the interesting thing was that although we had lots of support from Ted and other helpful people, it didn't really catch on. **[From the floor:** Do you mean the group didn't catch on?]. The group didn't catch on. I was its first chairman, and having been, so to speak, trained by the LMG, not as a London person but as a quite frequent participant in its symposia, I stressed the importance of the initiative coming from the students. The staff would try to help implement what the students put up to us, what they wanted to talk about, and to find people [speakers], but we got very few initiatives back from the students. In the end we, the staff, were in danger of running it ourselves. I think I did it for three years and then handed over to a colleague and I don't think it lasted very long after that. I don't know if there are similar experiences in other medical schools. So, I think that was rather sad.

Lock: I am only speaking from having read some of the literature, but it seems to me that at that point, and Ted could confirm this, that the LMGs were more or less decaying everywhere, in spite of the fact that the Pond Report, which we will come to after tea, had said that the LMG should go on. In fact like the Marxist state, it withered away, isn't that so?

Shotter: Not quite like that, it was a deliberate decision to close the LMG down, once medical schools had started appointing lecturers and once the GMC education committee had declared that it should be part of the curriculum.⁷⁷

Lock: Although Pond had said you shouldn't?

Shotter: That's another matter. But there was hard economics in this, because half the income of the LMG derived from grants from the Conference of Metropolitan Deans, the other half, my salary, came from a Leverhulme Fellowship.⁷⁸ Once the University [of London], through the medical schools, put money into ethics by appointing lecturers, there was no possibility of continuing with the LMG. So rather than have it wither away, I just stopped it.

Lock: We will come to that after tea, because obviously the Pond Report is incredibly important.

⁷⁶ Jones and Metcalf (1976).

⁷⁷ See Appendix 1, pages 112–13.

⁷⁸ See Appendix 1, pages 103–4.

Arie: Here is a totally different tack. One of the things that I particularly remember – I am reminded of it by these pamphlets that nostalgically have been passed around today – is the incredible efficiency, indeed meticulousness, with which things were put together. I was always impressed by the fact that the LMG got everything right: it told you where you would be, who else would be there, who the audience would be, how long you should speak, and, amazingly if you look at this [the LMG lecture lists circulated at the meeting, for example, see Appendix 3], there was an almost, dare I say it, an almost obsessive correctness, right down to the letters after one's name. I think that ought to be noted.

Vernon: My impression is that those who showed the most interest in medical groups tended to be general practitioners, paediatricians or obstetricians. Now I don't know whether that is reflected elsewhere, but that certainly has been our experience. It will be interesting to see whether that was the case as well in other provincial medical groups.

Dickenson: As Bill Fulford is here now, I wondered if Bill would like to say anything about the Oxford experience, of the clinical ethical rounds which you helped to set up in psychiatry. Taking things back to psychiatry, I worked with Bill on these for many years, and, I think, before me Jonathan Glover was also involved, wasn't he? These [rounds] were used for the house officers and the registrars and so forth, so this is relevant, I think, to post-qualifying in training in psychiatry. Perhaps Bill would like to say something?

Professor Bill Fulford: Actually it was Sid Bloch who originally set up those clinical ethics seminars.⁷⁹ You are right, it was a very hard-nosed department, very scientific in its orientation. The department was set up by Michael Gelder, at a time when a distinguished professor of medicine in Oxford was seen moving the placecards at a dinner so his wife didn't sit next to a psychiatrist.⁸⁰ So you know they had everything to play for in terms of being absolutely top-notch in terms of scientific quality and so on, and Michael Gelder very much encouraged these seminars. We had one a term, which was quite a significant proportion of our scientific programme. Sidney Bloch got them going. I think Richard Hare originally contributed to them before Jonathan Glover, and they were very well attended. Donna and others supported them tremendously, and it enriched the programme.

⁷⁹ See, for example, Bloch and Chodoff (eds) (1981). See also Bloch (2005).

⁸⁰ Gelder (1990, 1995).

My other recollection of Oxford, to tie in with an earlier speaker although slightly at a tangent, is part of what led on to the work that Tony Hope and I did – again with Donna’s help originally – in setting up the Oxford Practice Skills Programme.⁸¹ We also did a survey – I think one of the earlier speakers said that they did a survey of the medical students and at the same time a survey of the Deans.⁸² We did a survey of our consultant colleagues and at the same time a survey of our students, and got exactly the same gap of perception. All our colleagues said, ‘Yes, of course, we are teaching ethics’. All the students said, ‘What’s ethics, where do we learn about that?’ That was one of the ways in which the Oxford Practice Skills Programme got going. I think that student perception is something that we should be going back to, in terms of what we are doing today.⁸³

Lock: I wonder if I could ask Malcolm Macnaughton whether the medical Royal Colleges were concerned about this dearth of postgraduate education before the Pond Report?

Macnaughton: Yes, I think so. In the Royal College of Obstetricians and Gynaecologists, of course, I think the issues moved the ethics. There was first of all the abortion business and in 1967 Sir John Peel, who was the President of the College at the time, managed to get the Council to agree on the Abortion Act in 1967, with some difficulty, I think.⁸⁴ The next development that occurred was IVF in the 1970s and, of course, there was a lot of discussion at the College, fed on to the Fellows and Members, so they were educated as far as that was concerned.⁸⁵ Then came the Warnock Committee, of which I was a member, and after that we set up in 1985 this voluntary licensing authority, which I started, and ethics came into that, and the College Fellows and Members were

⁸¹ Hope *et al.* (1996), which includes a comprehensive reading list by subject.

⁸² Fulford *et al.* (1997). See also Professor Gelbier’s contribution, pages 31–2.

⁸³ Professor Bill Fulford was one author of the RCGP’s *Curriculum Statement* of 2005, which noted that ‘values, although not always recognized for what they are, stand side-by-side with evidence in all areas of healthcare decision-making, whether clinical or managerial, individual or team-based’ [page 5]. See www.rcgp.org.uk/PDF/educ_ethicsAndVBPsfRCGPCouncilDec2005.pdf (visited 13 June 2007).

⁸⁴ RCOG Council (1966); Diggory *et al.* (1970); Potts *et al.* (1977). See also James (1971); Halfmann (2003), especially Table 2, 575–6 for events leading to abortion legislation in Britain and the US. For later discussion of the 1976 Select Committee on Abortion, see *Hansard* (21 June 1990): Cols. 1145–50. See also pages 12 and 19.

⁸⁵ Anonymous (1985a).

taught about that.⁸⁶ At least they were told about what was going on, and there was lots of discussion about it. And then HFEA came in, and that was criticized by the College and papers were written and distributed about that. And the latest thing of course is the resuscitation of very premature babies. And the College has just issued a document about that.⁸⁷ So that's how it was, educating people by issuing documents on the issues of the day.

Lock: I am sure we should mention the General Medical Council (GMC). We have Professor Bryan Jennett here who was a member of the GMC. Would you like to comment?

Professor Bryan Jennett: I think, of course, *Tomorrow's Doctors* was where the GMC made its impact.⁸⁸ I mean prior to that, when I was on it, it seemed to me that the GMC was interested only in alcohol and adultery. It was not interested in competence or what we would now regard as ethics.

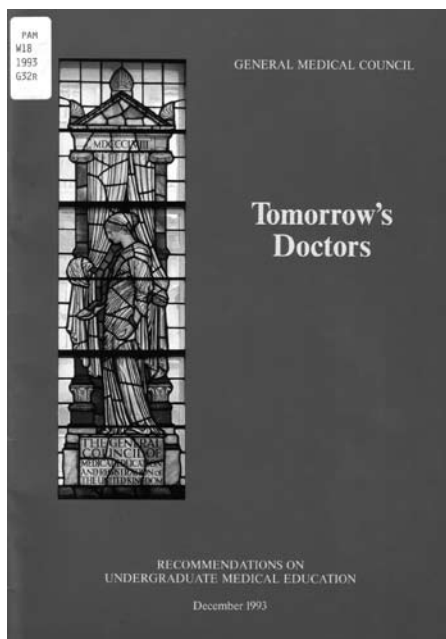


Figure 8: Cover of the 1993 edition of *Tomorrow's Doctors*.

⁸⁶ Committee of Inquiry into Human Fertilisation and Embryology (1985).

⁸⁷ Royal College of Paediatrics and Child Health, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (2006).

⁸⁸ General Medical Council, Education Committee (1993).

Lock: The size of nameplates on doors, as well.

Jennett: That's right, yes, the etiquette. But I was going to say a word or two about the nursing, because during my deanship [Dean of the Faculty of Medicine, 1981–88] our development of the teaching of ethics, before Pond, emanated from the nursing department.⁸⁹ Professor Downie, whose name has been mentioned, was Professor of Moral Philosophy and had been giving a course of lectures to undergraduate nurses. The doctors and medical students then started to come to me, asking: 'What's all this ethics business, we don't hear about this in our half of the world, so to speak?' Downie and Calman and I were all there at the time, and we developed ethics teaching as a result really of Downie via the nurses.⁹⁰

Lock: What year would this be?

Jennett: That would be 1983/4. And the teaching then was in the 'Environment, behaviour and health course' in the second year, where Downie gave a series of lectures. Then he, Calman and I would give lectures during the third and fourth year. One of the interesting aspects of Scottish education in this field was the place of medical jurisprudence, which had very strong departments in several of the medical schools there, and as late as 1987 the medical jurisprudence lecturers were given the task of dealing with consent, confidentiality, negligence, quality of life and ethics of dying. Of course, this is a group of people who never had customers who answer them back, or have any discussion with them. And it seemed to me that one of the things that we were trying to do was to prise it [medical ethics] away from that neck of the woods, so to speak.

Lock: And you were successful eventually?

Campbell: Could I follow up this point about the nurses? I am very glad that Bryan Jennett made the point. Actually, when I came back to Edinburgh in 1965, it was to discover that at the Royal College of Nursing, Edinburgh, but also in the Royal College of Nursing (RCN), London, there was a postgraduate course for senior nurses to prepare them to be very high up on the Salmon

⁸⁹ See pages 29 and 41.

⁹⁰ Downie and Calman (1987); Jennett (1994); Randall and Downie (1996). Professor Robin Downie was unable to attend the Witness Seminar.

ladder.⁹¹ And in that there was a very major course in ethics, which I was then asked to teach to the RCN. I did it from 1965 to 1970. I don't know who invented the syllabus, but it was full of the ethical theory of Hume, Kant, and even Spinoza, and had obviously been devised by some fairly cruel philosopher somewhere who had decided that nurses needed it. But in any case, it was very clear that from that time, from 1965, certainly onwards, the RCN was very much dedicated to the idea that postgraduate nursing should contain ethics.⁹² And I think already the International Council of Nursing had already developed ethics codes, ahead of some of the medical codes, and chairs began to be set up that were clearly devoted to the ethics of nursing.⁹³ So I do think it is a pity that there isn't a nursing person here today. I am sure this is accidental, but I think there is a major history here, that was running parallel and of course the medical groups very much involved the nursing people in them, so from that point of view there was cooperation there.

Boyd: I want to add that the first book that we really needed on medical ethics, *Moral Dilemmas*, came out of Alastair's course.⁹⁴ It was from nursing that you got that. Then in other colleges, nursing colleges, quite a lot of us were involved in that process.

Dickenson: I would agree with Alastair and Ken, that nursing, in some ways, perhaps, was more advanced. In 1985 when I was doing my doctorate, I was asked to teach a course at Oxford in the academic nursing department there, which was run by Sue Pembrey and Barbara Vaughan, who would certainly be worth getting opinions from.⁹⁵ And that was really devoted to nursing ethics. There was already the development of nursing ethics as a separate set of concerns,

⁹¹ Professor Alastair Campbell wrote: "The "Salmon" ladder was a new grading for senior nurse managers – I was lecturing to those seeking the higher grades." E-mail to Mrs Lois Reynolds, 24 January 2007. See Ministry of Health (1966). The enquiry into senior nursing staff structure, chaired by the businessman Mr Brian Salmon, did not include clinical duties and pay. The 1966 report proposed a new grading structure matching nursing and administration grades and the opening of the promotion path to the highest levels of nursing administration to all. The application of this structure from 1967 was not entirely as envisaged: matrons disappeared and unit officers took on management positions without formal training; many had to reapply for their own renamed positions. See www.nhshistory.net/1958-1967.htm (visited 1 May 2007). See also Berridge *et al.* (2006) for details of administrative changes in public health.

⁹² See, for example, Way (1962).

⁹³ See, for example, International Council of Nurses (1966, 1973, 1974, 1976).

⁹⁴ Campbell (1972).

⁹⁵ See, for example, Pembrey (1980); Vaughan (1990, 1991, 1996).

and there was a particularly strong interest in the use of the ethics of care, and a reaction against principlism, I suppose. There was quite an extensive use of some fairly difficult authors. I was interested that someone said even Spinoza, I think it was you, Alastair. We didn't so much use Spinoza, but Nel Noddings, who was quite difficult, along with a wide range of case material as well.⁹⁶ So I would just like to reiterate that, I think, in many ways the nursing ethics scene was very far advanced and that there was a strong sense that they had an individual identity.⁹⁷

Dr Michael Wilks: This is not on nursing ethics, this is going to be moving on. It was really just to pick up what you were beginning to invite us to talk about, which is the issue of learning about ethics education, about ethics beyond the graduation point. I recall, as a medical student in London, between 1967 and 1972, going to LMG lectures and feeling that I was in a kind of parallel universe, because it was so clear to me what wasn't being taught back at the medical school. If I may just digress slightly, I think that created an interesting problem as a medical student and as a young doctor, because it was quite frustrating and quite worrying to be exposed to the lack of teaching and then to face dilemmas, both as a student as a young doctor that I had no way of resolving institutionally, in other words, through the medical school or through senior clinical staff. And I remember how ill-equipped I was as a postgraduate. And I think that that is something that has bothered some young doctors and I suppose some of them took some action over it, more through political means.

I was going to mention another source of teaching, which is not a very good one, because it is teaching in a crisis, where doctors ring up medical defence bodies [the Medical Defence Union (MDU); Medical and Dental Defence Union of Scotland (MDDUS)], the BMA and the GMC with a dilemma, and then being taught about the dilemma at the time of crisis, which is hardly very good. But the experience that the BMA's Central Ethical Committee [renamed the Medical Ethics Committee in 1988] had was as a result of getting these rather anxious phone calls from doctors who were clearly very ill-equipped to deal with their dilemmas, due to a lack of basic teaching that we in the BMA then started to produce publications [guidance].⁹⁸ I think probably an

⁹⁶ See, for example, Noddings (1984).

⁹⁷ For a more recent view, see Parsons *et al.* (2001).

⁹⁸ The BMA's *Handbook of Medical Ethics* first appeared in 1980, revised in 1981, 1984, 1985 and 1986, and appeared as *The Philosophy and Practice of Medical Ethics* in 1988 [BMA (1988)]. It set out the broad framework, including the ethical codes, that binds the profession, such as the Hippocratic Oath and various World Medical Association declarations, along with appropriate bibliography.

important book was *Medical Ethics Today*, which then filtered back into medical schools to use as a basis for undergraduate teaching among, obviously, many others.⁹⁹ And through some political activity, being the BMA, which I think it is worth recognizing, unusually, has had and has a very high professional aspect to its work, in other words ethics and international affairs which many national medical associations tend not to, that was also able to put pressure on medical schools and on the GMC to produce documents like *Tomorrow's Doctors*, which I think then took things forward.

Professor Sir Christopher Booth: Just a brief comment about research ethics. I worked at the Postgraduate Medical School, Hammersmith Hospital, from 1954 to 1977, and was Professor of Medicine there from 1966. Therefore I was there when Pappworth's book came out in 1959, when Beecher's book in Boston came out in 1967, and, of course, when Kennedy gave his famous Reith Lectures, and it was those three things that made the biggest impact on ethics in terms of research.¹⁰⁰ Before that people didn't bother. Nobody in this country took the Nuremberg Code seriously, it was considered to be a code for barbarians, not for us, and the Americans took the same view, except for the American Medical Association (AMA).¹⁰¹ But I think that what did matter, as far as postgraduate students were concerned, was that the ones that came to Hammersmith were Australians and New Zealanders, brought up to expect a very high ethical standard of clinical work, and some of them were extremely unhappy about the things they were asked to do by their consultants at Hammersmith. Many became students of Pappworth's, because he gave courses in postgraduate teaching, and they paid him money for it.¹⁰² And out of that came the contact between the postgraduates at Hammersmith and Pappworth, which led partly to Pappworth's publications.¹⁰³

⁹⁹ Sommerville (1993).

¹⁰⁰ Beecher (1959); Pappworth (1967); Kennedy (1980).

¹⁰¹ 'These codes [are] necessary for barbarians but [not for] fine upstanding people.' [ACHRE 1996: 86]. See Riis (2001): 373. For the American Medical Association's Principles of Medical Ethics, see Baker *et al.* (1999). The US did not immediately ratify the 1964 Helsinki Declaration because of its potential effect on research, although the Surgeon General's policy revision of 1 May 1969 clarified the US policy on informed consent and the requirements for all scientists receiving National Institutes of Health grants. See Faden and Beauchamp (1986): 200–32.

¹⁰² Pappworth taught a private course for the Membership of the Royal College of Physicians (MRCP). Hazelgrove (2002): 118.

¹⁰³ For details of the awakening of ethical responsibilities, see Pappworth (1990).

Lock: I think that's very important. I think one has to remember that there had been a series of parliamentary questions about human experimentation in the mid-1950s.¹⁰⁴ I don't know what prompted it, and people talk about Pappworth being relatively late, after the LMG. In fact Pappworth's first article was published three years before the LMG started, so I think it's important to get the time right.¹⁰⁵ I myself think that Pappworth was a very influential person.

Gillon: Yes, if we are talking about postgraduate teaching, I think that we ought to remember that a whole series of courses were developed as Master's of medical ethics of one sort or another. I think the first was not a Master's but the Diploma course at the Apothecaries, but shortly after that Ian Kennedy started his first Diploma, which then developed into a Master's at King's, followed by Swansea and Manchester. Then, I think, they spread all over the country, so there are lots of Master's and higher degrees.

Lock: This is after Pond though, isn't it, and Pond is after tea?

Gillon: I don't think so. The Apothecaries course started in 1978, Kennedy's Diploma course in 1981; the Welsh MA in 1985, the Manchester MA in 1987, along with the upgrading of the King's College London diploma to an MA, and publication of the Pond Report, also in 1987. I should also mention that we started a one-week intensive course in medical ethics at Imperial in 1983 that tried to sensitize people to medical ethics. I think these postgraduate courses are a pretty important phenomenon.

Lock: Yes, indeed. We certainly were going to mention them. While you have got the microphone, Item 6 on today's programme is for you to sum up the influence of the LMGs.

Gillon: I have not been primed to do this [subject], and it's something that Ted is writing, on behalf of the Institute of Medical Ethics at the moment.¹⁰⁶ My own view is that they were a tremendously important development, for all sorts of reasons, but especially because they started with the students. This is

¹⁰⁴ The House of Lords debated two motions drawing attention to unnecessary suffering caused by surgical and medical experiments on animals [*Hansard* (1952) 178 (98): cols. 631–58; *Hansard* (1957) 204 (92): cols. 1337–68]. See Home Office, Departmental Committee on Experiments on Animals (1965): 13–14.

¹⁰⁵ Pappworth (1962, 1990).

¹⁰⁶ The Witness Seminar Programme outlines a number of broad topics and some participants are invited to 'start the ball rolling' with a short introduction, in this case 'Influence and Impact'. Ted Shotter's report on this appears as Appendix 1, pages 71–117.

something we may need to recall when teaching the subject in medical schools today. But students' views of what's important and how to respond to those views are a pretty important component; as important as student interest is the backup of support from the teachers responding to it.

One thing, perhaps a minor thing, but somebody has already mentioned it, is that eating together – eating and drinking together, I should say – is a rather important part of the socializing component of learning. I think that is something that we need to remember, again in the context of what the LMG taught us, because we don't get very much of it these days in teaching in medical schools. Three other things that Ted has emphasized about the LMG approach, and that are important for contemporary medical ethics teaching – stemming from Gordon Dustan, I suppose – first a sympathy to the medical profession, something that's decreasingly evident today, along with an assumption, or at least a presumption, that doctors go about their work honestly and honourably and with good intentions. And secondly, that the details of the particular case are always a tremendously important starting point, and thirdly, that consideration of the scientific information and evidence is also very important for ethical analysis. I think all those are lessons from the LMG approach.

Lock: I wonder if I could ask Ian Kennedy how much he was aware of the LMGs before he wrote his Reith Lectures, because looking at them again he says that today – meaning I think 1980 – there seems to be a sudden beginning of interest in the topic.

Professor Sir Ian Kennedy: Thank you. I am sorry I was late in arriving, and I have missed some of the early conversation. I was going to talk about this a little bit after tea in my allotted disquisition. But, no, Ted will know more than I, because his memory is better, but I was involved in the Institute and the medical groups from, I don't know, the late 1970s or thereabouts. And so I was well aware of them, as I will explain after tea. I was probably best described as a critical friend of them.

Lock: Welcome to the second half. If we are looking at this chronologically – as we are in some ways, I think – we next come to what I described as the *Rite of Spring*, Stravinsky's effect, meaning Ian Kennedy's Reith Lectures. And having recently bought a copy of these extremely expensively on Amazon, I can't resist reading out a quote:

I have already indicated my view that education in ethics must be an essential part of medical training. Doctors need not be threatened by

this, nor need they regard it as interference. Instead all will benefit, the future patients, society in general, and the doctor who, at present, is left to muddle through some awesomely difficult problems and often criticized for whatever he does.¹⁰⁷

Ian, I think that's a good introduction to what you are going to talk to us about.

Kennedy: I think you are kind, Stephen, not least for a good introduction, because it's my own words. The brief you, or Tilli, gave me, was to speak for a very few minutes about the background to the Reith Lectures, and then shut up and preferably leave and let you talk among yourselves. So I will race through the odd note I have here. Can everybody hear? I gave a speech the other day where I asked whether people could hear, and a chap said he could, but he was quite happy to swap with someone who couldn't.

The background to the Reith Lectures was that I, as I have already indicated, had a long involvement with the Medical Groups, and the Institute, through Ted and others. As I said, I was something of a critical friend of the Medical Groups, because I thought they were a wonderful innovation, but – and there was a but – I thought that they ran the risk of preaching only to the converted, namely, the people who came to the lectures were the people you didn't need to have at the lectures, and the people who didn't come were the ones you needed to reach. Secondly, they were no substitute, nor did they claim to be, for a systematic education. And merely looking to students to lead us to what was important, might sometimes mean that students didn't recognize what might be important. And thirdly, I thought they were a bit inward looking, that they were almost all doctors talking to doctors, though that's an over-statement.

A further bit of background. As has been said, I was involved at King's in founding a centre that was concerned with medical law and medical ethics in 1976. And that was to set up teaching at postgraduate level, and indeed at undergraduate level, as soon as possible, with the help of people like Raanan Gillon and Roger Higgs and others. It was nice to hear Kenneth [Boyd] talking about teaching nurses, because I ran a course where I taught nurses and preclinical medical students. Together. The only meta-purpose was that they would understand each other, their similarities as well as their differences. Plus we were involved in GP training through Luke Zander out in Lambeth [The Warren Practice].¹⁰⁸

¹⁰⁷ Kennedy (1983): 118.

¹⁰⁸ For details of research in general practice, see Tansey and Reynolds (eds) (1998).

And, I remember, in Southampton, as well as research and public lectures. The public lectures were held at lunchtime; I remember we had 800 people come to hear Mary Warnock and that was an extraordinary hour. It was a sense of the degree of interest felt by the student body. I invited a woman named Jean Renvoize – I doubt anybody in this room except Janet [Radcliffe Richards] remembers her – she had written about incest.¹⁰⁹ She spoke between 1 o'clock and 2 o'clock, that was the lunchtime break, and at the end of her lecture she said: 'Anybody who has been touched or affected, or recognizes anything in what I have said, and who wants to talk to me, I will be outside in the quad.' I don't know if any of you remember the layout of King's. She didn't leave the quad until 5 o'clock that afternoon. It was most extraordinary. That not only said something, but it also indicated what you could do by having courses like that where you touched on the complexities of modern life.

So the Centre existed and also a third piece of background, as I said, to the involvement of the groups founding the Centre with others, [for example,] with Gordon Dunstan, was being involved in radio programmes. In the 1970s I had made [radio] programmes about things like spina bifida and screening, assisted suicide, mental health. That led to an invitation in the spring of 1979 to put up a treatment for the Reith Lectures. It was then the only piece of programme content that the Board of Governors had the jurisdiction to decide upon. They requested three, four, or five options, and then they chose. And they chose this subject, which was broadcast in the late autumn of 1980, having been decided upon in early 1979. So the BBC was accused of by chance coming upon a subject of interest, because cases like Dr Arthur and so on had just come into the public consciousness.¹¹⁰ In fact, it was a considered decision, they could see where the wind was blowing.

About the Reith Lectures: they weren't principally – and this is important to know – about medical ethics. Only the fourth of six lectures addressed what might now be called medical ethics.¹¹¹ The major themes, if I can say – others identified their own – were that what is now called healthcare, then called medicine, was a social and moral enterprise as well as anything else, and the values implicit in that

¹⁰⁹ Renvoize (1982).

¹¹⁰ Dr Leonard John H Arthur, was charged with murder for ordering 'nursing care only' (sedation, water and starvation) for John Pearson (b. 28 June 1980), a Down's Syndrome baby who died 60 hours later. The charge was altered to attempted murder arising from possible congenital heart failure and Arthur was cleared at Leicester Crown Court on 5 November 1981. See Usher (1981).

¹¹¹ Kennedy (1981): 76–139.

enterprise were not made explicit in that enterprise. And, secondly, the patients were neither heard nor listened to, to the degree which may be appropriate in a modern civilized society. Those are two fundamental themes. There were five lectures, other than the fourth on ethics, and in those days you had to give a lecture of 28 minutes and 30 seconds, in a closed studio with no chance of talking to anybody – no feedback except from the producer doing hand signals. Some commented upon the delivery or the fact that it was a little bit ‘in the face’, as the Americans would say. But you have to remember the dynamics of the occasion: you have to keep your audience. And I once did a programme where I broadcast nothing for 20 seconds, which was a man admitting that he had killed a patient, for good reason I might say, or at least in his mind. And 20 seconds is a very long time not to have anything on the radio, because one starts hitting the set, saying that the bloody thing has gone off. So, the dynamics of maintaining an audience are not like Daniel Barenboim appearing in front of people, conducting and playing a piano, as he is currently doing. The other five lectures were on things like language and power in the context of healthcare: The language of illness, the language of disease, and the notion that the relationship between professionals and clients is a relationship of power, which isn’t malign, but needs to be understood. And this drew upon the work of people like Illich, like Foucault, and also a man named Bernard Barber at Columbia University, who was an expert in the sociology of professions.¹¹² Then there was a lecture, or a couple of them really, about health policy, about the need to move away from acute sector care to primary, to preventive care, to health promotion. I said in one of the chapters that hospitals should be regarded largely as a failure of healthcare, except in certain circumstances.¹¹³ I heard Lord Warner say that only about six weeks ago when he introduced the White Paper on preventive care: twenty-five years late.¹¹⁴ I thought, ‘Well, that is not bad’. And that was drawing on people like McKeown, and Muir Gray, great figures of the time.¹¹⁵

The second bit of health policy was the concern for what are called the vulnerable – I don’t think they are vulnerable, we make them so – children, and the elderly in particular. I had one chapter called ‘suffer the children’ and, of course, there were echoes of that when I was asked to do the Bristol inquiry, as nothing had

¹¹² Barber (1963).

¹¹³ See Kennedy (1981): 26–50.

¹¹⁴ Department of Health (2006).

¹¹⁵ McKeown (1976); Muir Gray (1979).

changed.¹¹⁶ And then I wrote about mental health, and I had a whole lecture on litigation, which was headed, even though people perhaps didn't notice the title 'Let's kill all the lawyers, first let's kill all the lawyers'. I was arguing that we should get rid of medical litigation as being the fundamental barrier to safe care, because people buried their mistakes, rather than admitting and learning from them. The fourth lecture was, as I recall it, about what we would call ethics, and it had three themes really. The need to separate out the discourse based upon values from other components of the medical transaction between patient and doctor. Secondly, because there was that discourse, the need to educate professionals in how to engage in that discourse, recognize issues. I shall never forget sitting and hearing evidence in Bristol of a young doctor saying that he was sent to 'consent' patients, this was in 1999–2000. First of all, I never understood the verb consent to be a transitive verb, but over and above that, what did that say in 1999 about an understanding of the relationship between patients and doctors, that you are sent to consent a patient, rather than ask that patient for his or her consent. So, there is a need to educate professionals. And thirdly, a need for healthcare professionals to engage with and take account of patients. Not as it is now, the Government's position 'a patient-led NHS', which is, I think, as Jeremy Bentham said, not mere nonsense, but 'nonsense upon stilts'.¹¹⁷ I was looking for a partnership where each party recognizes the ability of the other. The patient knows about him- or her-self, the doctor knows about the care of him- or her-self. I will go on for another two seconds.

The initial response to the Reith Lectures: I have a file at home, which I still can't take out of a drawer without using fire tongs.¹¹⁸ But leaving that aside, there was a huge empathy from the public at large. It had the highest audience of any series of Reith Lectures, and sold more copies of *The Listener* at that time, because they were first published in *The Listener*. However, it divided professionals, particularly doctors; nurses were very keen on the idea, but I think because there was a subtext, a subtext that they put into it, which I hadn't, namely putting doctors in their place. Not a view I held, but there it is. Among

¹¹⁶ Bristol Royal Infirmary Inquiry (2001a and b). Professor Sir Ian Kennedy, Chairman. See also Bristol Royal Infirmary Inquiry (2000); Department of Health (2001).

¹¹⁷ 'Natural rights is simple nonsense: natural and imprescriptible rights, rhetorical nonsense, nonsense upon stilts'. *Anarchical Fallacies* (1843) in Schofield *et al.* (2002): 330.

¹¹⁸ Reactions to the Lectures include: Swales (1980); Anonymous (1981); Cruickshank (1981); Black (1981). See also Kennedy (1981, 1982, 1983a and b).

professional doctors, pioneers, the Donald Irvines of the day,¹¹⁹ as it were, were very keen, they saw in it something that they could build upon in their own journey. Many, particularly those representing organizations, were anti. And I pay tribute to, for example, the Hammersmith, because my first invitation after giving the Reith Lectures was from Keith Peters of the Hammersmith, within a week or so, to an extremely hostile audience. Keith said, ‘Well, hang on, give him a chance and let him talk’. I wasn’t able to persuade anybody, but I got out with my life. The reason for the initial antipathy, which I recognized, and which took the form of letters in the *BMJ* saying: ‘Could next year’s Reith Lecture be given by a doctor – subject: the legal profession?’¹²⁰ Fine. I could do one on the law with them if they wanted. The reasons were, I think, surprise, almost shock that someone outside medicine would or could comment upon healthcare. Secondly, a degree of unease about what was being said, particularly in relation to imbalance of power, or a disequilibrium of power, and the idea that medicine was value-laden, and the idea that one hadn’t had a preparation in how to deal with such an area of practice. And those, I think, were the reasons for the initial antipathy. I think over time a lot of that has gone away. And the sort of things, like concern for education, concern for primary care, concern for the vulnerable, are now so ‘Ho Hum’, one wouldn’t even notice them, but at the time they weren’t. So if I were to put it in any historical perspective, I would say that it was part of a process, and maybe to a degree a catalytic event, though it wasn’t intended as such. And I will finish with an anecdote about my brother, who was a surgeon. On one occasion he was called out to operate during a broadcast of one of the lectures, so he asked that the lecture be left on in the theatre so that he could listen to it. And no sooner was it put on than the registrar turned it off. And my brother who was a very mild-mannered chap, said, ‘Hang on a second, I want to listen to that, that’s my brother’. To which he replied, ‘I don’t care who the hell it is’, and it stayed off.

Lock: Now, who would like to comment first?

Booth: I remember when the [Reith] lectures came out in 1981. Hammersmith always was an open-minded place. I remember when Pappworth’s book came out, one of the first people to ask him to come to dinner were the junior doctors at Hammersmith, and I am glad to hear what Ian Kennedy has said.

I think there was a strong reaction in the medical profession at large against the

¹¹⁹ See biographical note on page 180.

¹²⁰ Buckland (1981).

idea that their paternalism was being challenged, and to some extent I regard the Reith Lectures as being one of the key events in the retreat from paternalism in medicine. The idea that medicine was a social question which involved many other people, many other disciplines, I still get this – we are reviewing a paper at present from America, with somebody talking about the history of *our* profession. Well it's absolutely ludicrous to call medicine our profession. It isn't the case. I think Ian Kennedy's lectures made this point very clear, and so far as I am concerned, it was an eye-opening moment and I congratulate him.

Riis: There are many similarities to such a broader social scope in other countries in the reactions to what you did, and to the necessity of doing what you did. Because I didn't find the chance to mention it before tea, one of the very important steps is to bridge the gap between science and all the people surrounding and patients, and the society and such. Søren Kierkegaard [(1813–55), the Danish philosopher and theologian] said that if you want to move somebody from one place to another, first find out where they are and start there.¹²¹ And that's so simple, that anyone of us who heard it, could think that we could be philosophers, or even were philosophers, but it's precisely what scientists and others, and all those surrounding patients should do if they are seriously interested, go out there, in church groups, in public groups, and write in newspapers, to try to bridge the gaps. Our experience in the Nordic countries is that such bridging removes tribalism. We have had an enormous amount of tribalism between nurses and others, but it's away now, even the media haven't been able to keep it open. So, this is just a Nordic parallel.

Campbell: I think one of the things that has been mentioned already is the conferences of the medical groups, and one of the conferences that I remember extremely well was one where we had Ivan Illich, the author of *Medical Nemesis*, as one of the speakers [in 1975].¹²² I think it illustrates that the medical groups didn't stand outside medicine, criticizing it, they stayed within medicine, but they were not afraid of controversy and criticism, and it's a very subtle balance that, but it was done by allowing this range of topics, some of them extremely controversial, often fraught with the kind of controversy that seemed irresolvable, like a termination of pregnancy, or whatever, but was able to have it aired and have it aired in an atmosphere in which there was genuine sharing between different points of view. I think this is another reason that the medical

¹²¹ 'If one is truly to succeed in leading a person to a specific place, one must first and foremost take care to find him where he is and begin there'. Kierkegaard (1859).

¹²² See Illich (1975a and b); Stewart (1975).

students really liked the medical groups, because I think they found a different atmosphere from the traditional atmosphere of medical teaching there.

Lock: Does anybody know whether the groups discussed the theories of Thomas McKeown, which Ian has mentioned? Now although there wasn't so much anger about it, there was a lot of controversy. I mean, McKeown said that on the whole medicine had been irrelevant to the reduction in illness and premature death, and the death rate from tuberculosis started going down in about the 1820s, and really health was due to better bathrooms, and better steak for dinner, rather than to penicillin, and he got a lot of stick from his fellow physicians, I think.¹²³

Tait: I was very grateful for Sir Ian Kennedy's Reith Lectures. One of the things that I want to bring out was the way in which ethics became an important issue with the introduction of vocational training schemes for general practice from the 1970s onwards.¹²⁴ There was a real desire to change the culture of young doctors going into general practice. I don't know how many trainees there were in any one year, taking the whole country – several hundred maybe – and that has continued now for 40 years. What effect all this has had in terms of actual ethical behaviour is another question. But, anyway, right back at the start, the Reith Lectures were very important in suggesting the need for a change in attitude.¹²⁵

Lock: I wonder if we could just pursue that with you, because I think it's a logical place to say about your survey of ethics teaching for trainees in general practice. You did a survey I think in the late 1980s–early 1990s.

¹²³ See, for example, McKeown and Record (1962); Porter (1999); Szeleter (2002) .

¹²⁴ Horder and Swift (1979). See also Paulley and Tait (1983).

¹²⁵ Dr Ian Tait wrote: 'One of the texts – not quite a required text, but nearly – was Ian Kennedy's Reith Lectures. They were important ammunition. It is interesting to think how large was the potential audience for training in ethics, perhaps we should call it applied behavioural science, which was presented by vocational training in the 1970s onwards. These schemes were required to include a day-release course in their programmes. Ethical issues were an important element. How well we coped with them is another issue.' Letter to Mrs Lois Reynolds, 4 January 2007.

Tait: Yes, nearly into the 1990s.¹²⁶ Let's go back to training schemes [for general practitioners]. One of the things that we obliged training practice to do was for the trainer to have one-to-one tutorials with his trainee, at least once a week. When we reviewed these sessions, it wasn't the practice of clinical medicine that was the problem. It was the ethical problems, the behavioural problems, on which the trainees most needed guidance. But the trainers didn't have a language in which to help.

I went on Raanan Gillon's course at Imperial College – I think it was in 1888, I mean 1988 [much laughter]. Sometimes it feels like that. I remember the course very well, it was extremely stimulating and I came back and said, 'Well, there is a thing called the principles of ethics and we need some sort of structure to this'. I started trying to devise courses, and went around our region [East Anglia] to take over at the day-release courses for short periods. I tried the ethical lecture, but it didn't go down at all well, and it obviously didn't work that way. When I started asking, 'Have you got any problems? Have you had problems in this area?' Well, I was flooded. Some of the problems were extremely distressing, with young doctors who had been in very difficult situations and had to make decisions that they still remembered with great pain, and wanted to talk about. And that was an extraordinary experience for me. I then turned the trainees themselves into an 'ethical committee' to have some kind of structure to help them to discuss their own cases, so as to tease out these situations, and give them some objectivity. I used a modified form of David Seedhouse's ethical grid, but I know there are others around.¹²⁷ And it did work, I think, rather well, but there was no follow-up in this kind of area, so you don't really know how they performed ten years later as principals in general practice. But, at the time, it did work.

¹²⁶ Dr Ian Tait wrote: 'In 1989/90 I carried out a study of "The Teaching of Medical Ethics in GP vocational training schemes". At the start I wrote to all GP Regional Advisers, who were responsible for training schemes in their Regions and asked for information on the training of medical ethics. Twenty-eight replies were received, 15 regions had no specific input of medical ethics; ten organized 1–2 lectures a year, 11 left the subject to individual Course Organizers to cover their case discussion in some way. The replies revealed considerable uncertainty about how fast to teach medical ethics to young doctors and doubts were expressed about ethical lectures divorced from specific clinical situations. My study confirmed the need to study ethics in relation to the doctors own personal clinical experience.' Notes for Witness Seminar meeting, 9 May 2006.

¹²⁷ Seedhouse (1988).

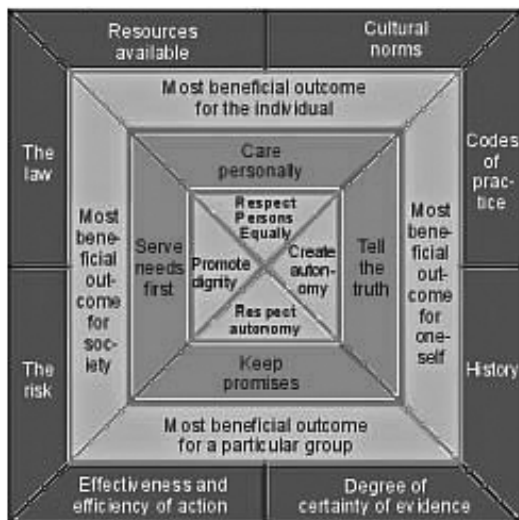


Figure 9. One example of the evolving Seedhouse ethical grid.

Inner section: health care purpose; second section: duties; third section: consequences and outer section: practicalities.

See Seedhouse (1988): 141. For more recent developments, see <http://southstaffshealthcare.values-exchange.co.uk/> (visited 1 October 2007).

Shotter: May I follow that up by pointing out that junior doctors, who had themselves been involved in the LMG as reps, formed themselves into a postgraduate advisory group to see what might be done among qualified doctors. I think this was about 1970 or 1972. Professor Dick Welbourn, Professor of Surgery at Hammersmith, chaired this group, and from this was developed the Society for the Study of Medical Ethics, which became the Institute of Medical Ethics in 1984, but also perhaps most importantly in the publication of the *JME*, which obviously was designed to penetrate into postgraduate life.¹²⁸

Mrs Iris Fudge: I am a nurse and an observer here. But I wonder if the problematic nature of the ethical practice of psychiatry has been addressed. I won't go into the power struggles that take place within psychoanalysis, even though some of those psychoanalysts are practising doctors as well. But in psychiatry in particular, where notions of who holds the power, and for whose good, is very much an issue.

Arie: I was a bit diffident in responding to your earlier question about the teaching of psychiatrists in the times that we are considering. But, with regard

¹²⁸ See www.medicalethics.co.uk/ and <http://jme.bmj.com/> (visited 31 July 2007).

to the question of how psychiatry responded, I think ‘profoundly’ is the answer. The Royal College of Psychiatrists, for instance, is now deeply, so to speak, married to patients. On our committees we have users of services, we have committees on almost every topic that is shared with patients. We very much like to liaise with voluntary organizations in the fields relevant to us, and have projects with them. So I think the brief answer is that psychiatry is doing its best to respond powerfully to the changing scene in this regard.¹²⁹

Jennett: At the risk of exceeding the deadline of 1993, I just thought I would like to say a word or two about the teaching of medical ethics in a problem-based curriculum, the new curriculum that’s becoming popular. The reason being that [in Glasgow] this is almost entirely in the hands of the Department of General Practice, and the Department of General Practice employed a full-time philosopher for several years, and has now followed that up by employing a sociologist, shared between the other medical schools in Scotland, to be the kind of lead person in doing the teaching of medical ethics, and this of course is done in small groups of eight students. There are about 30 general practitioner teachers, who first go to 12 training sessions. They are involved right through from the first year of the medical course, giving a weekly seminar. So, it was general practice that led the way in this teaching of ethics since 1996.

Higgs: I wonder if I could just bring in another angle. Combining some of the things that Ian Tait has been saying with what we have just been discussing, I think that my generation – becoming a general practitioner as I did in 1975 – was greatly influenced by the publications and the work of Balint and the Balint Society.¹³⁰ I suppose the probable link that I am looking for with medical ethics is that there was a realization that when there were difficulties in the relationship between a doctor and a patient, it wasn’t just that these were ‘difficult patients’, but Balint turned the searchlight on the ‘difficult doctor’ and asked why was that doctor having a particular problem in this way. And that gave a way in which young and old within the groups could discuss what was the real issue that one was trying to deal with; was it something within one’s own experience, or was it one’s own set of attitudes that was creating the difficulty here. Now I personally think that we are in great danger of now having lost that from

¹²⁹ For details of the Mental Health Research Network and their Service Users Research Group for England (SURGE), see www.mhrn.info/dnn/ following link to Service Users (visited 5 June 2007).

¹³⁰ Dr Michael Balint (1890–1970) was a psychoanalyst from Hungary. See www.balint.co.uk/ (visited 30 April 2007); see also Balint (1957). For background details of Balint’s work with general practitioners, see Reynolds and Tansey (1998): 126–9; 174.

medical education. Just before I retired from King's [College London], my first lecture of the year was given to 1400 people, because it was thought best to be multidisciplinary; the current orthodoxy was to bring nurses, dentists, everybody in healthcare training, together. When I started in teaching, it was one-to-one, and I think that we have got to re-find, somehow, the ability for us to be able to get down to the individual learner in training, and enable that individual learner to ask, 'What are *my* issues?' For instance, as one of my trainees would have said, 'Why don't I want to go to see a dead body?' Another question would be: 'Why do I find it so repugnant to deal with somebody who has had a sex change operation?' These sorts of issues, as Ian was saying, which come out of a discussion with a young person, don't, as far as I know, appear in any other guise in medical training at the moment, and I think that that is in itself an ethical issue that we have to keep an eye on.

Morton: Could I pick up on one or two points on the undergraduate education. In 1990 and 1991 we set up a course in Birmingham Medical School allocating about 50 hours of teaching to the undergraduates, which was, I think, quite a lot at that time.¹³¹ We had a clinician doing the first hour and he would bring patients in – for example, a homosexual with HIV – which raised all sorts of issues. And then, on the basis of that lecture, the students divided into small groups for an hour's discussion. So, 50 per cent of the course was discussion based on the lecture which had gone on beforehand. We had to set up a bank of 80 tutors, in order to provide 20 or 30 for each session, so each small group had no more than ten people. To sell it to the faculty, I hitched law to healthcare ethics, because law's always a great driver for doctors. But perhaps another key point was that we made ethics on a par with anatomy and physiology, so it was a subject within the core curriculum, which students could fail. That was a great impetus to attendance and for them to take a serious interest.

Kennedy: I just wanted to come back on one thing. I do think Roger [Higgs] is absolutely right to have put his finger on something which, in historical terms of those of us who were engaged in the late 1970s–early 1980s, were trying to solve, which was how to create a cadre of teachers who could go out (not the amateurs), although they wouldn't be as good as Roger or Raanan immediately, and that's why we set up those postgraduate courses and MA courses. It was a real desire to create teachers as much as anything else, who could then go out

¹³¹ A survey of medical ethics teaching in London reported that of the 12 medical schools, ten were teaching the subject three years after the Pond Report, although the time allocated ranged from half a tutorial to 24 hours. See Burling *et al.* (1990). See also Arnott (2002).

and carry the word, and I think that's still the case, because we are still behind in terms of how many people we need. I mean, I don't think we will ever get back to one-to-one, Roger, but certainly 1-to-1400 is a bit daft, and that remains a challenge, to teach the teachers.

Dr David Misselbrook: As a GP in southeast London in the 1980s, I was one of those people I suppose you were targeting, and I am happy also to remember Luke Zander as someone being very influential to me. Luke drew a number of us into what was then UMDS of Guy's and St Thomas' Medical Schools before we were joined with King's, and Luke drew a number of GPs into teaching ethics. And there was something of a feel that while we were enthusiasts, it was a matter of 'Oh, gosh, we have got to find someone to teach ethics, the GPs, we had better stick it in their bit, because you know they are enthusiastic, good-natured people, they must be able to teach it'. And as a then quite young, enthusiastic and I hope good-natured person, I did my best. And we took the view of really bringing cases and trying to involve medical students with cases, and also attempting to then teach basically principlism [principle based ethics, applied to determine logically the best ethical resolution of its issues or dilemmas], which was our way into trying to open up these cases.

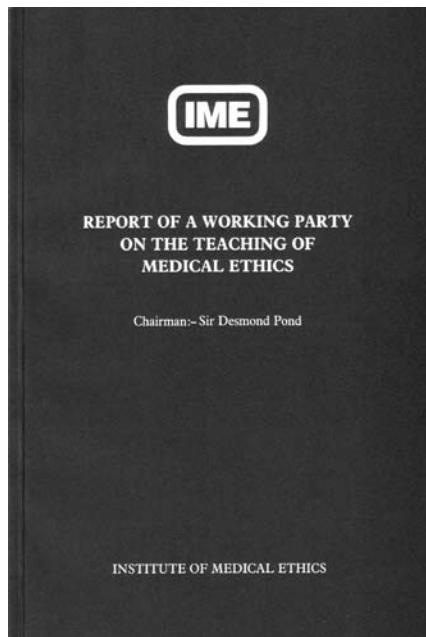


Figure 10: The Pond Report, 1987.

I then became recycled, as it were, as a general practitioner course organizer in the 1990s, and my observation over those ten years was that the young GPs, the qualified doctors coming to us in the 1990s, didn't have very much more idea about ethics than the students we were teaching in the 1980s, so obviously I hadn't taught them very well in my neck of the woods. But as has already been said, there was a huge advantage in teaching in a general practice setting, both in the vocational scheme where you would have highly motivated people engaging in very immediate conversations about cases they had dealt with that week and that really bothered them. And, secondly, as a GP trainer, on what Ian has already referred to as this one-to-one opportunity, and as a GP trainer in the one-to-one you have a much greater opportunity to engage in depth in some of these issues. So my experience is that it has been a slow and hard process.

Lock: I now want to switch, if we may, to the Pond Report while we have still got Professor Boyd.

Boyd: Its origins [the Pond Report]: one of Ted's great talents was always finding someone who would be an inspiring chairman for our research groups, and we were very fortunate in this case to have Sir Desmond Pond shortly before he died. In fact he read the final draft just before he died. We already had the experience in Edinburgh I've spoken of [earlier], of trying to look at what was most appropriate in one medical school and discovering one set of people thinking they were teaching medical ethics, and the people who were being taught thinking they were not being taught. So we had a national survey, and we brought together a group and, there are various people [here] in the room – Bryan (Jennett) – who were members of the group; and their main recommendations were that there wasn't one pattern for teaching ethics in medicine, there should be a lot of different experiments.¹³² But there should be some protected time [in the curriculum], and there should be somebody responsible for seeing that it happened, and responsible, as someone [Kennedy] has just said, for teaching the teachers. I think these were among the main recommendations.

That's oversimplifying it a lot, but the group did not want to have a didactic programme of telling people – we recognized that medical students were not philosophy students, that's why they were medical students – and therefore

¹³² The Working Party, convened in 1984, was supported by a grant from the Nuffield Foundation, and had 13 members with a secretariat of five. Appendix 2 of [Boyd (ed.) (1987): 51–60] includes papers on 'Philosophy' by Dr Jonathan Glover; 'Moral Theology 1' by Professor Keith Ward; 'Moral Theology 2' by Fr Brendan Callaghan; and 'Law' by Professor Gerald Dworkin. See Glossary, pages 199–200.

you had to teach them in a different way. I think the report had quite an influence there.

I would just like to add one thing, because just a couple of months ago, the Institute of Medical Ethics and the BMA held a conference on learning, teaching, and assessing medical ethics, to see what's happened since the time of the Pond group.¹³³ There's been a lot of progress, but there are also still medical schools which do not have what was recommended by Pond, not even one full-time person responsible for ethics education. And, there are some, regrettably, that are going backwards, and have had people to teach, and no longer have them. These are the bare bones.

Jennett: As you said about the membership, the Pond Working Party had 16 people on it, a relatively limited committee, and doctors were in the minority which I think is important, and I think there's certainly five or six of us here today who were members of that.¹³⁴ I think that the questionnaires uncovered an enormous variation in practice at that time, some doing very little, and some doing quite a lot. So I think it was the first attempt to show how unsatisfactory the teaching of medical ethics was. Most of the Deans did respond and there were over 30 students representing all the medical schools.¹³⁵ Interestingly enough, some of the students said they didn't think there should be any teaching in medical ethics, that they were taught enough from their consultants and didn't want any more, thank you. The features that were recommended included the involvement of philosophers, theologians and the law, who were regarded as having analytical skills: the implication being that doctors didn't. There was also the recommendation to avoid domination by those committed to one viewpoint, which is worthwhile putting in black and white. It said that the sessions should be at a good day in the week and a good time of the day. In other words not at 5 o'clock on a Friday, which was where some people tucked away their ethical teaching, thereby indicating that it was an optional extra. And it also recommended that there should be inclusion of medical ethics in postgraduate education

¹³³ 'BMA calls for urgent review of ethics teaching to improve patient care', BMA Press release, 2 December 2003, at www.bma.org/ap.nsf/Content/PR21203 (visited 9 January 2007).

¹³⁴ See Glossary, page 200.

¹³⁵ Seven questions were asked in the survey: the medical school's policy on ethical teaching; timetabled periods; encouragement of informal discussion; non-medical teachers; assessment and encouragement of student's familiarity with ethical issues; extra-curricular activities; and the respondent's own views on medical ethics teaching. The responses were analysed in Chapter 3 [Boyd (ed.) (1987): 15–34].

continuing and in medical education. And the last thing it said was that the matter should be reviewed in five years. In effect, that review was the GMC's *Tomorrow's Doctors* in 1993, which really endorsed the Pond Report, but gave it teeth by saying that it should be part of the core curriculum, thereby giving it a legal standing. I think it's worth commenting that five years after that, in 1998, the *JME* has its Consensus Statement, in which 43 teachers of medical ethics and law in the UK made a report on what the present situation was then, and they identified 12 topics that should be covered and made an actual list of these.¹³⁶ So it was almost a curriculum, if you like, that was set out for the first time. What's interesting is that the April 2006 issue of the journal of *Medical Education* had a paper, 'Revisiting the Consensus Statement', which was another update of the Consensus Statement, and they did a questionnaire of 22 of the 28 schools who responded.¹³⁷ Only three were teaching all 12 consensus topics adequately, three were missing at least one topic and four said that there were topics that although they were paying lip service to, they didn't really feel that they were dealing with them adequately. In fact, only 16 schools, half the schools, had a dedicated person who was, if you like, leading the teaching of medical ethics. I think it was the Pond Report that led to those other reports which then updated the situation.

Lock: We have five members from that Working Party here.¹³⁸ I wonder if Brendan Callaghan would like to make any further comments.

Callaghan: The brief answer at this moment is 'no'. I was just looking at my contribution to the actual published version. I am at the stage where I think: 'Good heavens, did I manage to say that, or formulate those thoughts?', because they are much clearer than anything I could do now.¹³⁹

Nicholson: Again, most of what I would have commented on has been said by Bryan Jennett. I am a bit worried about whether there really has been follow-up and in particular, as Bryan has just reported suggests that the GMC is not taking this subject seriously in its five-yearly inspections of medical schools, and I think that's the fundamental problem. Until the body that has the legal responsibility

¹³⁶ Consensus Statement by teachers of medical ethics and law in UK medical schools (1998). See Glossary, page 194.

¹³⁷ Mattick K, Bligh J. (2006b). See also note 143.

¹³⁸ For a list of members, see the Glossary, page 200. See also note 132.

¹³⁹ Fr Brendan Callaghan contributed 'Moral Theology 2', one of four papers in Appendix 2 [Boyd (ed.) (1987): 56–8].

for the conduct of medical education takes it seriously, we are going to have all this variety. Certainly my own experience is that if I am asked to go for talks in postgraduate medical centres, I have never yet been to one where more than half the doctors present say that they have ever had any teaching whatsoever in medical ethics.

Lock: Ted Shotter, would you like to add something?

Shotter: No, I don't think I would.

Lock: I wonder if we could ask about the nuts and bolts of the Pond Report. I wonder why three Deans did not respond, for instance. Was it a very long questionnaire, because we had more students responding? I think the students from every medical school responded, whereas three Deans didn't.

Boyd: No, we tried. Subsequently we have done quite a bit of follow-up, such as the recent survey that Bryan has mentioned.¹⁴⁰ The original questionnaire wasn't very big, it wasn't all that complicated, as far as I can remember. Actually I think a lot of people would have thought that that was a reasonable response rate, because even with the most recent questionnaire, we have exerted pressure, twisted arms, phoned people up, and even then there were two or three schools that didn't reply.

Lock: Could one suggest that perhaps Scotland was doing rather more than England before the Pond Report? I mean if you look at the appendix of the activity that was going on in the Scottish medical schools, it seems much greater than anywhere else.¹⁴¹ Malcolm Macnaughton, what would you say?

Macnaughton: As far as I can remember, I think it had a great impact in Scottish medical schools, but we always had some ethics during clinical teaching. If there was an ethical problem, say in transplantation or something like that, then it was discussed at the time, and that was the way it was done, there wasn't a formal lecture in ethics.

Gillon: Yes, I think one of the issues that came up in the Pond Report fairly clearly that still hasn't been resolved was the differentiation of two ideas about medical ethics: one of them being teaching people what they jolly well ought

¹⁴⁰ Mattick and Bligh (2006b).

¹⁴¹ Appendix 1 of the Pond Report gave details of the Deans' replies about timetabled periods of formal teaching at their institutions [Boyd (ed.) (1987): 43–9]. The replies from Scotland appear on pages 46–9.

and ought not to do, which is the traditional understanding of medical ethics, and the other is teaching them [students] about analysis of why they ought or ought not to do it – to encourage the capacity to reason it out, and understand the opposing points of view. I think that component has been emphasized only in recent times. I think people enjoy doing it once they get stuck into doing it, but it's still a major problem to differentiate in teaching medical students and doctors between these two approaches and the conflation of the two is still an ongoing problem.

Booth: Just on the Scottish question. In the University of St Andrews, which is my university and where I graduated in 1951, we were unquestionably taught about the Hippocratic Oath, and what it meant. When we graduated, we were all lined up before the Dean after our graduation, and we had to repeat a version of the Oath afterwards, so we got some medical ethics even then.¹⁴²

Boyd: Well, that's very reassuring to hear. Was it in Latin as well? But if I could just follow Raanan's point about the two sides of medical ethics, because that is a problem, but I think it's also something that the Pond Report emphasized, that you had to have both, and you had to work at having both. Both saying what as doctors you ought to do, but also why, and where you could question it. And that's surely the challenge to ethics teachers, and again as it has come up, even in the most recent conference, it seemed to be important that you have to have both sides of both the teaching of what you ought to do, but also the critical intellect as well.¹⁴³

Higgs: May I make two comments, one about the Oath? When I first went into general practice, I asked one of my patients what she had been told at the hospital – this was 1976 – and she said [in a very cockney accent]: 'Well, they don't tell me nuffin', doctor, 'cos they got that oaf'. And while I was trying to work out who the oaf was that she was talking about, I realized that she

¹⁴² See Glossary, page 196.

¹⁴³ A workshop on 'Learning, teaching and assessing medical ethics' was held on 29 March 2006, organized by the Institute of Medical Ethics, the British Medical Association, and the Higher Education Academy Subject Centre for Medicine, Dentistry and Veterinary Medicine. For a preliminary report of the conference, see www.medev.ac.uk/workshop_resources/59/list_contents following the links to Conference report (visited 20 June 2007). See also Consensus Statement by teachers of medical ethics and law in UK medical schools (1998); Mattick and Bligh (2006b).

meant the Hippocratic Oath.¹⁴⁴ From her point of view, having been born at the end of the Victorian age in working-class London, she was very clear that doctors took an oath not to tell the patient anything, and that was her view. There's a sense in which we now need to revisit these things which might have seemed 'solved'.

My second, and more political point is that I think the problem for ethics education at the moment is that it's got entangled in medical schools in a lot of the curriculum battles, and many of the curriculum battles are very negative. You might find yourself having to discuss with the professor of anatomy as to whether it should be ethics or dissection or something ridiculous like that. We can't take our eye off the ball, because Deans have to make decisions, and may suddenly decide the best way of saving money is to chop out the ethics guy, as he's a nuisance anyway. So these things permanently have to be revisited and defended. As a general practitioner, I can say that there are some dangers for ethics being allied with certain areas, and, that's fine for instance, if general practice is a powerful department. But as often, if general practice is not a powerful department, you will then find that ethics will go down the pan, because you haven't actually got yourself 'linked in'. In the old days, Ted Shotter was very clear that we should link in with the main powerbrokers within the medical schools.

Riis: Could I ask if one of the 12 points was distributive ethics? Because the problem of what I have called collectivity ethics, in contrast to individuality ethics, is that many of the dilemmas that doctors and other decision-makers meet today even in our affluent societies, not only with transplantation organs, but also with things that you could buy for money, has to be distributed according to such ethical principles of fair distribution.

¹⁴⁴ Professor Roger Higgs wrote: 'Without wanting to spoil the joke, it is important to emphasize that neither the original Oath nor its modern equivalents were actually sworn by most new doctors on qualification at the time of this woman's comment to me in 1975. The Hippocratic Oath is of course silent on the question of whether patients should be told the truth about their conditions, but she was right, that most senior specialists at that time did not follow modern thinking (that proper consent is impossible without the patient knowing why the treatment suggested is necessary). As medical registrar in a London teaching hospital in 1973, I was instructed specifically by my consultant – at the time a young man who eventually became a leader in UK medical education – not to tell patients what was the matter with them. Such instructions were part of a group of experiences that influenced me to choose to work in general practice rather than in hospital and to try to bridge the gap between the pragmatic approach of even the most well-meaning of the clinicians who spoke to us at Medical Group meetings and theoretical ethics as taught in philosophy departments.' E-mail to Mrs Lois Reynolds, 19 August 2007.

Vernon: I think I will just amplify a bit what Richard Nicholson said about the GMC having the power to influence courses, having said that ethics has to be both taught and assessed. I think that also gives ethics teachers considerable power within their own medical schools, to say how are we going to meet this obligation that the GMC are putting upon us, and that's almost like the reverse of self-censorship in a sense, that rather than wait for the GMC to come, say well look we have got to have something that's going to be good enough to suit them, and I think that would be quite powerful.

Lock: Well, I think there's time now for general discussion. Anybody can raise anything, and I think it would be a very good idea if they did. I think one of the impressions that perhaps we haven't given is what enormous fun some of the group activities were, and what a privilege it was to participate in them. I would not like any recording or account of this to omit that particular consideration.

Campbell: It wasn't actually about fun, they are not very good at fun in Scottish ethics. I just wanted to mention a little bit more about the *JME*, although it's been mentioned once or twice in passing. This may sound not very modest of me, because I was the first editor, but only for the first five years, and then for the next 20 endless years, many years, of course my neighbour on my left, Raanan Gillon, and it has since gone through two changes of editorship. But I don't think one should underestimate the importance of this development of an academic journal, which Ted identified the origin of in the group that was looking at the importance of postgraduate medical education. One of the extraordinary stories of the *JME* is that when I was editor my biggest worry was finding papers of reasonable quality, and there were really hardly any around, it was very, very hard. I had to commission a great deal, we relied on the conferences which had very good speakers to try to get scripts from conferences and so on. One couldn't imagine a different situation from that of the journal today, in which it and I think most people know that it is a collaboration with the *BMJ* – as it has been from the beginning – so it has the sort of standards that a *BMJ*-associated journal must have and today the journal has moved from a quarterly to become a monthly journal, and even then cannot deal with the volume of papers of high quality that are coming to it. Now this in itself, I think, indicates that the field of medical ethics began to become in the 1970s, and continued to become through the 1980s and 1990s, a genuine academic field of the kind that couldn't be dismissed as simply a bit of icing on the cake that you might give to medical students, but in fact is a field of genuine interdisciplinary scholarship. And one of the reasons, I think, the journal is so

important, is that it always stays with the philosophy of medical groups, which was that it had to be interprofessional, interdisciplinary, and it had to keep its roots in the practise of medicine or of healthcare as widely understood. So it doesn't attempt to be a philosophy journal or any other kind of journal, but really a journal that is anchored in medicine. So if you then begin to develop that sort of organ, then you are establishing a field, and a field which then can I believe be seriously examined as part of the medical curriculum and in other ways promote research. And so in one sense I think we have seen a mini-history of the events that we are interested in today, the history of the way in which the *JME* itself evolved and opened up and has developed to what it is today. And I have to finish with a funny anecdote about this, a story that Ted [Shotter] has told me, so it must be true. It's a story that when the Society was considering appointing an editor of the journal, they were quite sure it ought to be a doctor, and so they looked around and they couldn't find any doctors who knew anything about ethics, or if they did, could write about it. So one of the advisory committee, the late Charles Fletcher, said: 'There's this chap Campbell has published a book [**Shotter:** It was Archie Duncan who recommended Alastair.¹⁴⁵], this chap Campbell has published a book, he's not actually a doctor, but maybe it would be all right to ask him instead'. And that's how I became the first editor of the journal. Now these days, indeed since my time, we have been able to have a mixture of medical practitioners like Raanan and currently the editorship of the journal is shared between one person who is a medical practitioner and one who is a philosopher. And I think again it is a very interesting bit of history in the way in which the initial ideas of the medical group have actually taken some kind of institutional form.

Callaghan: This is a *non sequitur*, but it gets us back to 'fun'. You mentioned how much fun it was, many of the activities of the medical groups in particular, and that provides me with a peg for something that I had not quite got in before we broke for tea. Raanan [Gillon] made a throwaway comment about eating and drinking, and to those who know how the groups worked, that's quite an important reference. For the benefit of those who don't, you are going to hear it: at the end of each evening, after the actual formal discussion with medical students and whoever else was there, the local organizing students for that particular evening, at that particular medical school, and the speakers, were all taken out to dinner together by the LMG. And it was highly educative, probably for both groups, but there was a chance to continue the discussion,

¹⁴⁵ Campbell (1972).



Figure 11: Professor Archie Duncan and Professor Dick Welbourn, Chairman of the Editorial Board, at the launch of the *Journal of Medical Ethics*, 1975.

for relatively junior students to have a chance to sit at table and engage in serious talk with leading people. The fun element comes in as far as I remember, being the key phrase, because while I have got clear memories of some of these evenings, others are a bit blurred round the edges for some reason or other. But, we were well dined and very well wined as well.

Lock: I think that's probably a suitable point to end our deliberations.

Barr: It just occurred to me that we haven't touched on why the groups ended. Was it a job well done?

Lock: We have said 'finance'.

Shotter: As far as the LMG was concerned, in its last five years and pro rata before that, I had to raise what became £200 000 to £250 000 per annum in soft money. Once we had persuaded the GMC education committee – and I think we did think we had persuaded them – that ethics could be taught, and once the GMC education committee had required it to go into the curriculum [in 1993] or preferred it into the curriculum, and once the Deans had started appointing lecturers, in London, at least, half our income, was generated in grants from the Deans and the other half, my salary, came from Leverhulme. So suddenly it was quite clear that we were going to be unfundable. And indeed,

for a number of years, people like the King's Fund were saying they would not continue indefinitely, trusts like priming pumps rather than pouring money down a well. So when it became clear that the money would cease, I determined that it would be better to stop the LMG when it was a good story, rather than let it dribble away to nothing.

Now I can't answer that question, as I know nothing about what happened to the provincial medical groups, because I was then without a job (later I was transmogrified into being the Dean of Rochester), and though I stayed on the editorial board of the *Journal*, I had no direct dealing with any of the groups. But as far as London was concerned, it was closed down deliberately. Now various things happened in London after 1989. Graham Claydon at Tommies [St Thomas'] continued the programme on a local basis, based on the experience of provincial medical groups, as did the Royal Free, and Margaret Lloyd, who is not here, was in effect co-ordinating secretary at the Royal Free. I think they called it a medical ethics group, but I can't tell you the rest of the story.¹⁴⁶

Vernon: I can only speak for Newcastle about the withering, and I think the withering happened at about the same time as we got incorporated into the main medical course. So as medical ethics was taught more, so it became less something that was done outside. But one thing that I would say is that medical students now have a variety of other groups that they themselves have set up. MedScene in particular, Medical Students International, which does some of the more campaigning type of things that might have come up a bit within medical groups. So I wouldn't feel too anxious about voluntary activity. But just something else that I would like to throw in here, because it does seem to me that the whole process has been very effective, and if we look at some of the international conferences, say in medical education – the Ottawa Conference, Association of Medical Education in Europe or the home-grown one – you will frequently find papers there on healthcare ethics in one way or another, and I don't think that would have been reflected say 30 years ago in terms of the papers that would have been given. And even, I don't know if I dare say this,

¹⁴⁶ Hywel Evans, fourth year medical student and President, 2006/7, wrote: 'The Royal Free Medical Ethics Society is currently running under the name of the UCL Union Medical Ethics Society. We continue to host a number of events, the most high profile of which this year was an expert panel-led discussion regarding the ethical implications of avian influenza which involved the leading British expert in the field, Professor Robert Dingwall, Director of Science and Society of the University of Nottingham and a member of the Department of Health Committee on the Ethical Aspects of Pandemic Influenza (CEAPI), as well as other leading experts.' E-mail to Mrs Lois Reynolds, 29 May 2007. See also the CEAPI website at www.dh.gov.uk/en/PandemicFlu/DH_065163 (visited 11 June 2007).

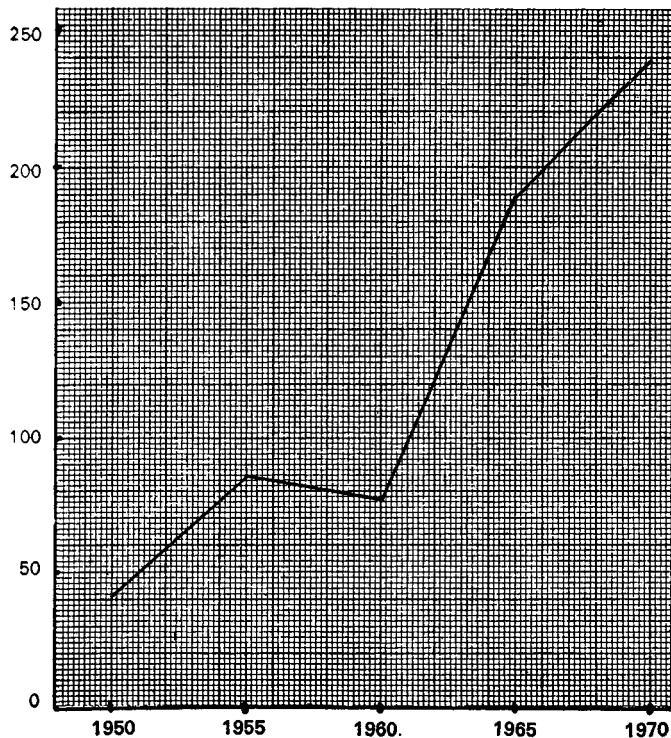


Figure 12: Number of articles listed under the heading 'Medical Ethics' in *Index Medicus*, 1950–70.

but there are far more articles about ethics in the *BMJ* itself than ever there would have been in the past. Just that sea change which I think we can be very glad about.

Lock: It's what is known as Whiggish history, things are getting better all the time.¹⁴⁷

Gillon: Yes, I just would like to add that the effects of the LMG I think are going to be continuing in one area, at least the Institute of Medical Ethics will be looking at the possibility of re-starting the annual student conferences that Ted got going or at least pump-priming. That is, if they agree.

Shotter: I was just going to say that this growth of interest in medical ethics, we have been putting down to much more recent years, but one of the student presidents of the LMG wrote a report, in which he looked at *Index Medicus* and

¹⁴⁷ Butterfield (1973).

this was between 1960 and 1970 [Figure 12]. During that time there was a 50 per cent increase in the number of citations in *Index Medicus* generally, but of those, there was a 300 per cent increase in those on medical ethics.¹⁴⁸

Booth: Just a point about research ethics. Listening to this discussion, and looking at the programme of the LMG all those years ago, one gets the impression that *research* ethics didn't figure very highly on the agenda of these groups. Speaking as a clinical scientist, this was the item that mattered most to us, and it was a very important part of our discussions during that period, because of the question of informed consent. And on informed consent what is interesting about informed consent is that a consent form was always accepted for surgical patients; all patients undergoing a surgical operation, even a minor one, had to sign a consent form. How informed it was is of course problematical. But that extended then into nonsurgical areas like medicines, when physicians began to do liver biopsies, cardiac catheterization, and so on. Now the tradition was for physicians not to ask for anything other than oral consent, nothing more. And that changed during that period. What was it that changed that? It wasn't the LMG.

Nicholson: I think one has to remember that of course the basis for the topics of the LMG was coming from the students, but between October 1968 and March 1974 there were five meetings about the ethics of clinical investigation, so effectively one a year. But the average attendance of students was under 70, so they weren't one of the more successful meetings, which is why probably we didn't put on more, because we were somewhat led by what students really wanted to hear about.

Lock: I think there's a natural time when all meetings should stop and I have managed to arrange for the wine to be served early. But thinking about our friend here from Copenhagen, I was looking at Michael Frayn's play last night of course about Werner Heisenberg and Niels Bohr. I am afraid he ends his postscript by saying:

History is not what happens when it happens, but what seems to people to have happened when they look back upon it.¹⁴⁹

I think that's what we have been doing today. We have had a marvellous afternoon. Thank you all very much for coming. There's some wine at the

¹⁴⁸ *LMG Annual Report 1970–71*: 9–10.

¹⁴⁹ Frayn (1998): 148.

back and I think that we should return these LMG documents to Ted for his archives.¹⁵⁰ Thank you all very much.

Tansey: May I also add the thanks of the meeting to our Chairman who has been stimulating and got us to wine a little before time, which is always appreciated. May I ask you to join me in thanking Stephen for chairing an excellent meeting.

¹⁵⁰ See note 21.

Appendix 1

A retrospective study and personal reflection on the influence of the Medical Groups¹⁵¹

by Ted Shotter, 16 September 2006

Introduction

Aims and method

This report traces the development of the study of medical ethics in British medical education during the second half of the twentieth century in the then 29 British medical schools and their associated teaching hospitals by analysing the influence of the Medical Groups,¹⁵² which were set up between 1963 and 1989.¹⁵³

The decisive role played by clinical medical students in the promotion of extra-curricular lectures and symposia on issues raised by the practice of medicine at a time when medical ethics appeared to be focused largely on professional etiquette rather than reflection on moral dilemmas is recorded. I speculate on possible lessons for today's teaching of medical ethics offered by the medical group approach.

This study is based upon an analysis of published material, the responses to a questionnaire, the comments of those former LMG medical student representatives (reps) and my own recollections. Published material consists primarily of the lecture lists issued by individual medical groups, together with the *Annual Reports* of the London Medical Group (LMG) and the Institute of Medical Ethics (IME), and, to a lesser extent, the *Journal of Medical Ethics (JME)*, the *Dictionary of Medical Ethics*¹⁵⁴ and the reports of research projects,

¹⁵¹ This appendix is the final report for the Institute of Medical Ethics on the influence of the Medical Groups, 1963–89, by The Very Revd Dean Edward Shotter.

¹⁵² Medical Groups based on the London Medical Group (1963–89) were established in the following university teaching hospitals: Edinburgh (1967), Newcastle (1967), Sheffield (1972), Glasgow (1973), Birmingham (1975), Bristol (1975), Liverpool (1975), Manchester (1975), Cardiff (1976), Aberdeen (1977), Southampton (1977), Cambridge (1979), Dundee (1979), Oxford (1979), Leicester (1980), Leeds (1982), Nottingham (1989). See Appendix 4, for the topics covered by 13 of these 17 groups in 1981/2.

¹⁵³ Only the London Medical Group ceased operating in 1989. The other groups continued until they were wound down. For example, an LMG derivative, the Royal Free Medical Ethics Group continued to produce an annual lecture list, and may still be functioning. [Running as the UCL Union Medical Ethics Society, e-mail to Mrs Lois Reynolds from Hywel Evans, President, 2006/7, 29 May 2007]. See note 146.

¹⁵⁴ Duncan *et al.* (eds) (1977); Boyd *et al.* (eds) (1997).

initiated by the Edinburgh Medical Group and subsequently undertaken by the Institute.¹⁵⁵

The influence of the medical group method is assessed primarily from responses to the questionnaire circulated to the reps, those former medical student officers whose names were printed in the annual lecture lists and whose addresses could be found in the 2004 *Medical Directory*. However, while there is a complete run of LMG lecture lists from 1963–89, there is no such archive of the lecture lists of the Scottish and Provincial medical groups (17 in all), which were set up in all the British medical schools and their associated teaching hospitals. Thus the cohort of doctors who could receive the questionnaire was limited to those who were trained in the then 12 London medical schools and involved in the LMG.

A further limitation is that it proved impossible to identify former LMG reps from disciplines other than medicine, since only medical students were identified by discipline, while, for example, nurses and nursing students, social work and physiotherapy students were usually grouped together and listed as ‘other’.

None the less, of the 779 former medical students, named as hospital representatives in the LMG lecture lists, 483 were included in the *Medical Directory* and were sent the questionnaire in 2004/5.¹⁵⁶

A consultation attended by a cross-section of former LMG reps from 1967–89 was held to review responses to the questionnaire and to promote individual reflections of those present.¹⁵⁷ Professor John MacDermott, Undergraduate Dean at Imperial College, offered to facilitate a conference after this study had reported, to review the current status and content of the teaching of medical ethics in medical schools.¹⁵⁸

¹⁵⁵ See pages 106–8. See also Thompson (ed.) (1979).

¹⁵⁶ See ‘Forty Years On’, page 108.

¹⁵⁷ The meeting was held at the Hospital Infection Society, 19 October 2005, attended by Dr Martin Brueton (Bart’s), Treasurer 1967/8; Dr Brian Payne (Middx), Secretary 1969/70; Dr Peter Wilkinson (KCH), President 1968/9; Professor John MacDermott (Charing Cross), Executive 1970/1; Dr John Sedgwick (St Thomas’s), President 1973–75; Dr Simon Walford (London), President 1973/4; Dr Chris Mace (St Mary’s), Secretary 1978/9; Dr Helen Sherrell (Middx), President 1988/9.

¹⁵⁸ A conference on ‘Learning, Teaching and Assessing Medical Ethics’ was arranged by the IME on 29 March 2006, involving other stakeholders, such as the BMA, the Council of the Heads of Medical Schools and Deans, the Higher Education Academy for Medicine, Dentistry and Veterinary Medicine, the General Medical Council (GMC) and the Medical Defence organizations, such as the Medical Defence Union.

A similar consultation was held in Edinburgh, which brought together former representatives of the Aberdeen, Dundee, Edinburgh, London and Newcastle Medical Groups.¹⁵⁹

During the course of this study, the Wellcome Trust Centre for the History of Medicine at UCL arranged a Witness Seminar on ‘Medical Ethics Education in Britain 1963–93’, held on 9 May 2006.¹⁶⁰

‘By consultants with consultants and *in camera*’:¹⁶¹

A note on the climate of opinion in the 1960s

Medicine is not practised in a vacuum. During the second half of the twentieth century, an explosion of medical knowledge coincided with an epoch of rapid social change, which included, in Britain, abortion law reform, the decriminalization of homosexual relations and attempts to legalize euthanasia.¹⁶² In Britain, as elsewhere in Europe, the moral certainties of the early years of the century were increasingly questioned or abandoned, while the deferential society was being eroded. The privileged position of the professional, which accorded the doctor a place in the social hierarchy largely above criticism, began to change.

The LMG was developed against a background of both radical student protest and also of uncritical reporting of medical practice, typified by television broadcasts such as Dr Charles Fletcher’s *Your Life in Their Hands* and other programmes in which doctors were anonymous or shown in silhouette.¹⁶³ There seemed to be no discussion of the ethics of medical practice: one writer wondered whether there were doctors who thought ‘ethics was a county just across the river from

¹⁵⁹ Professor Kenneth Boyd, Dr Colin Currie, The Revd Dr Richard Fraser, Dr Andrew Fraser, Dr Ian Kunkler, Dr Maureen MacMillan, Mr Paul Preece, Mrs Myra Ross, Dr Roger Smith, The Revd Bryan Vernon and Dr James Walker.

¹⁶⁰ For the transcript of that meeting, chaired by Dr Stephen Lock, see Reynolds and Tansey (eds) (this volume): 1–70.

¹⁶¹ See note 173.

¹⁶² See, for example, Home Office *et al.* (1957); and British Council of Churches (1970) and Kandiah and Staerck (eds) (2002) on the Abortion Act 1967. The 1961 Suicide Act decriminalized taking one’s own life, but Lord Raglan’s Voluntary Euthanasia Bill 1969 and the 1976 Incurable Patients Bill failed to become law. A BMA report [BMA (1971)] concluded that the medical profession could not accept euthanasia. For more recent legislation, see Finlay *et al.* (2005).

¹⁶³ The year of 1968 was ‘les événements de mai’ in Paris. A BBC TV documentary series examining surgical practice from the point of view of both surgeons and patients, *Your Life in Their Hands*, was presented by Dr Charles Fletcher from 1958 to 1964. See Loughlin (2000).

Kent'.¹⁶⁴ But opinion was changing, prompted by the publicity following such developments as Christiaan Barnard's first heart transplant at the Groote Schuur Hospital, Cape Town, South Africa, in 1967 and Michael DeBakey's 1971 left ventricular bypass in Houston, Texas.¹⁶⁵ The transplant surgeons' need for live organs from dead bodies challenged established definitions of death.¹⁶⁶

The Ciba Foundation had responded by setting up a multidisciplinary group whose report, *Ethics in Medical Progress*, had noted that clinicians when faced with the consequences of new developments in medicine often appealed to the concept of the sanctity of life, without any reference to religious belief or definition.¹⁶⁷

This was the time when the writings of Pierre Teilhard de Chardin were creating debate and controversy.¹⁶⁸ In this context Dr Gordon Wolstenholme, Director of the Ciba Foundation, invited the LMG to hold a series of study seminars on 'The Future of Man', at its Portland Place house, which later became the regular meeting place of working parties associated with the IME's research projects.

It was also a time of debate following C P Snow's 'Two Cultures' lecture in Cambridge in 1959, in which he drew attention to the lack of communication between the arts and the sciences.

Medicine is in human terms the most significant of all technologies... That being so, people will have to understand what technology, applied science, science itself is like, and what it can and cannot do. Such understanding is a necessary part of twentieth century education. We require a common culture in which science is an essential component. Otherwise we shall never see the possibilities, either for evil or good.¹⁶⁹

It was against this background that the LMG began to develop its multidisciplinary method of responding to issues raised by the practice of medicine.

¹⁶⁴ Wilson (1970).

¹⁶⁵ See, for example, Barnard (1967); DeBakey (1971); Cooley (2001). See also the discussion on the Declaration of Helsinki in Pappworth (1990) and Jennet (1980); Pond (1980).

¹⁶⁶ For the background to the early heart transplant work in the UK and the debate over the definition of death, see Tansey and Reynolds (eds) (1999): 22–3, 32–9, 63.

¹⁶⁷ Wolstenholme and O'Connor (eds) (1966).

¹⁶⁸ Teilhard de Chardin (1959, 1964, 1966).

¹⁶⁹ Snow (1965).

However, medical ethics was on the agenda elsewhere. In 1969, G R Dunstan, was appointed to the new Chair of Moral and Social Theology at King's College, London (KCL), having previously initiated a series of multidisciplinary studies on, for example, some of the ethical problems raised by such new medical techniques as resuscitation and prolongation of life – or 'Prolongation of dying' as the *Lancet* put it – among other matters such as sterilization and abortion.¹⁷⁰ Dunstan would become widely recognized as a leading figure in this field, not least by the medical profession, and was the only priest to become an honorary Fellow of all the medical Royal Colleges in London.

Dunstan gave the opening paper at a conference on 'The problem of euthanasia' with typical clarity and precision:¹⁷¹

My function is to try to clarify the issues, by offering you some basic distinctions. Distinctions are the stuff of good debate; and if I may choose, and probably spoil, a metaphor from your own discipline, by means of distinction we can anatomize the argument, so that, delicately separating tissue from tissue, and pinning each down, we can get at the heart or the root of the matter, study it, and then decide what we ought to do.

Moral reasoning involves, as one of its processes, a balancing of one interest against others, and considering them altogether. We are seldom, if ever, free to read off a moral duty – a course of action – direct from a moral principle; life is never so easy. All real situations present a complex of principles from which we have to reason out the best rule of conduct we can. I hope – although perhaps I delude myself – I hope this preliminary exercise in clarification will help this conference in its reasoning.¹⁷²

¹⁷⁰ Anonymous (1962); Gillison (1962); Dunstan (1962, 1965a and b).

¹⁷¹ Dunstan (1975). *Documentation in Medical Ethics* was distributed to members of the Society for the Study of Medical Ethics (SSME), whose editors in 1974 were: Roger Higgs, Richard Nicholson, Edward Shotter and Anthony Thorley. *Documentation 4* announced that the new *Journal of Medical Ethics* would replace *Documentation* in spring of 1975, while the final issue, *Documentation 5*, would cover voluntary euthanasia and consist of reprints.

¹⁷² Dunstan (1975). Conference proceedings were published in *Contact* and reprinted in *Documentation in Medical Ethics*, No. 1 (1972). The *Nursing Times* [(1972): 163] commented: 'It is difficult to believe that conferences such as this one cannot result in better care, both in the hospital and in the home'.

His approach would be hugely influential on the LMG. He developed a dialogue with scientific experts to enable them to disentangle the central issues: ‘understand the science’ and ‘trust the practitioner’ were key maxims; a presumption of doctors’ good faith and good intentions were characteristic. No matter how good the moral theology or moral philosophy might be, Dunstan insisted on thoroughly understanding the science first. These attitudes informed the work of the LMG and its aim to study ‘issues raised by the practice of medicine’ rather than the study of medical ethics.

However, even given such sympathetic objectives, in the early days, not all doctors accepted the idea of multidisciplinary studies: a leading paediatrician, declining an invitation from the LMG to take part in a symposium, replied that if such topics were to be discussed at all, which he questioned, then they should be discussed ‘by consultants, with consultants and *in camera*’.¹⁷³

‘Fools rush in’:¹⁷⁴ the origin of the medical group method

Dame Cicely Saunders recalls that, although she ‘cannot date her first contact with the ideas that developed into the Medical Groups,’ she can remember:

a discussion with the original researcher and our agreement that the initiative, planning and development had to come from the medical students and recent graduates themselves.¹⁷⁵

The researcher was Andrew Mephram, a Columbia-trained physician and chaplain of the Littlemore Hospital in Oxford.¹⁷⁶ In a report on the nature of medical education,¹⁷⁷ Mephram recommended that medical students should be seen as part of the hospital, rather than the university, noting that:

There is no doubt that modern medicine demands technical skills and sound knowledge that take years of hard work to acquire, but students

¹⁷³ Professor Sir Peter Tizard (1916–94), LMG lecture list correspondence, as recalled by the author. See an interview with Sir Peter by Sir Gordon Wolstenholme, Oxford, 16 May 1986, at www.brookes.ac.uk/schools/lifesci/medical/synopses/tizard.html (visited 27 March 2007).

¹⁷⁴ Dr Jack Dominian, psychiatrist and founder of One Plus One in the early 1970s, as recalled by the author. See page 77.

¹⁷⁵ See Appendix 2, pages 119–22.

¹⁷⁶ Dr Andrew Mephram was a priest of the US Episcopal Church working with the SCM as a national secretary for medical students. See *LMG Annual Report 1965*: 5.

¹⁷⁷ Mephram (1963).

and qualified doctors alike can forget that all this struggle is made for the benefit of their patients. We are charmed and dazzled by the wonders of our learning. The latest drugs and newest methods are a seductive temptation. But when we forget the patient who is to take that medicine, and upon whom the newest methods will be tried, we begin to lose the great tradition of good medicine.¹⁷⁸

In response to the report, I was asked by Bishop Ambrose Reeves to look at medical education in the 12 London teaching hospitals. I was surprised to find that there was no teaching in medical ethics in British medical schools, despite the popular mythology about doctors taking the Hippocratic Oath. Having studied ethics (moral philosophy) for my degree and ethics (moral theology) in my ordination training, I was aware that ethics was taught in other faculties and determined to do something about it. Nevertheless, my initiative was characterized, in the words of Dr Jack Dominian, as a good example of ‘fools rush in where angels fear to tread’. But ignorance of medicine was an asset which allowed me to ask questions without the inhibition of a medical education.

The first four LMG lectures were arranged in 1963/4, following a discussion with medical students – Elaine Boulton, Royal Free Hospital School of Medicine; Margaret Rose, St Mary’s Hospital Medical School. One of the first lectures was entitled ‘Pain’, given by Dame Cicely Saunders, then a Research Fellow at St Joseph’s Hospice, who noted that by 1972 this lecture had developed into ‘The nature and management of terminal pain’, a topic which became an annual event. She recalls how:

their repeated request for the topic illustrates how the students continued to demand a look at the humanistic side of medical education. That the particular subject of end of life care is a challenging way of approaching this is illustrated by the number of Medical Groups in other cities that chose it as their inaugural lecture.¹⁷⁹

The initial lectures in London were sufficiently well-attended to encourage the arrangement for the following year, 1964/5, of a programme of eight lectures and a symposium, each held in a different teaching hospital.

It soon became clear that there must be structured input from clinical students if the choice of topics was to reflect the current concerns of those training to

¹⁷⁸ Quoted in *LMG Annual Report 1965*: 5.

¹⁷⁹ Dame Cicely Saunders, 2004, see Appendix 2, pages 119–20.

be doctors. Thus, the Representative Council of students drawn from the 12 London teaching hospitals came into being. It was this which identified the subjects for inclusion in the lecture list and it was this which was replicated in the Scottish and Provincial medical groups as they came to be set up. It was soon recognized as the *sine qua non* of the ‘Medical Group method’ and became a defining characteristic of all subsequent medical groups.

A direct consequence of a lecture list based upon a student critique was not only that topics were included which were not to be found in the medical curriculum, but also were either cutting-edge clinical issues or taboo topics, not discussed elsewhere. For example, Dr Christine Cooper’s lecturers on physical abuse of children identified sexual abuse long before this was discussed in the curriculum, let alone in the media. And, Mr Patrick Steptoe’s presentation in January 1979 at a packed symposium at St George’s Hospital, Tooting, London, entitled ‘The first *in vitro* birth’, was held only days after the birth of Louise Brown, and depended entirely on the accuracy of advice from the Consultative Council, which advised the LMG on the choice of lecturers.¹⁸⁰ Fortunately, Louise was not late for dates.

Conference	Date	Conference	Date
The welfare state	1965	Pain: a necessity?	1978
Aspects of guilt	1966	Violence	1979
The prolongation of life	1967	Death: the last taboo	1980
The pattern of medical care	1968	The creative urge	1981
The new poor	1969	Appropriate medicine	1982
Diseases of civilisation	1970	Human rights in medicine	1983
The quality of life	1971	The cost of cancer	1984
The problem of euthanasia	1972	Sex and sexuality	1985
Survival of the weakest	1973	The search for the perfect baby	1986
To treat or not to treat?	1974	AIDS, ethics and medicine	1987
Iatrogenic disease	1975	Children at risk	1988
Death: the conspiracy of silence	1976	AIDS, sex and death	1989
Human sexuality	1977		

Table 1: LMG Conferences, 1965–89.

From the start there were also conferences on significant themes, convened by a student, and destined to become a major annual event, attracting large audiences and ‘deservedly popular and imaginative’, in the words of Cicely

¹⁸⁰ See note 186.

Saunders.¹⁸¹ Following one such conference the issues discussed reached the pages of the *Church Times*. Douglas Brown, writing on life and death issues of medical ethics, noted:

Young people entering the two callings in which death is a central element – the medical profession and the church – are little, if at all prepared for it in its reality, in its ethical and emotional complexity, however well they may have been prepared in theory....And that, of course, is not really surprising. They come from a milieu in which death is now a taboo. Indeed, the title of an oversubscribed conference at the Middlesex Hospital was ‘Death: the last taboo’. The conference was organized by the London Medical Group, an organization dedicated to the ethics of the practice of medicine which seems to hide its light under a bushel but has an importance to medicine, to other disciplines and to the Churches in inverse ratio to the amount of publicity it courts. Death, of course, is only one of the LMG’s concerns, but arguably the most important... The LMG faces at the highest level of scholarship and experience... the problems of death, not only at annual conferences but year in and year out at its lectures and symposia, including the distinction between killing and letting die, the fear of death, bereavement in old age, the dying child.¹⁸²

In this context, it is significant that the most mentioned topic recalled by respondents to the questionnaire [Appendix 6] was Cicely Saunders’ lecture on ‘The nature and management of terminal pain’, while the Russian archbishop and former surgeon, Anthony Bloom, gave a lecture on ‘Preparation for death,’ which was, by popular response, also repeated annually. Both consistently attracted large audiences.

Evidence of influence

Douglas Brown’s article sees evidence of the widening influence of the LMG when ‘those who lectured provided the main corps of contributors to the monumental *Dictionary of Medical Ethics*,¹⁸³ while one of its authors, R B Welbourn, once remarked that he ‘could not wait until the present student officers of the LMG reached the postgraduate scene’.

¹⁸¹ Dame Cicely Saunders, 2004, see Appendix 2, pages 118–21.

¹⁸² Brown (1981).

¹⁸³ See also note 186.

Further evidence of the growing influence of the Society for the Study of Medical Ethics (SSME) came during the 1969 debate on Lord Raglan's Voluntary Euthanasia Bill in the House of Lords,¹⁸⁴ when Lord Amulree drew attention both to the need to include the study of medical ethics in the training of doctors and also to the response of medical students to the LMG; while the Bishop of Durham, Ian Ramsey, formerly Nolloth Professor of the Philosophy of the Christian Religion and Fellow of Oriel College, Oxford, called upon medical educators to look seriously at the medical curriculum in this regard.

Papers presented at these annual conferences began to reach a wider audience when published in the *JME*. An editorial entitled 'An end to violence?' commented:

The choice of the topic of violence for the 1979 Conference of the London Medical Group is a significant one. Increasingly doctors and other health service workers are becoming aware of the social context of medicine. Violence is an apparently inescapable feature of that context (which) manifests itself daily in Accident and Emergency Departments, the phenomenon of child battery being a particularly horrifying example. But violence also has subtler effects on the incidence of disease and disability... The products of a society which generates a destructiveness blindly seeking an outlet in violence against self or others.¹⁸⁵

However, although all of the credit for the choice of topics must be accorded to clinical students, whose insight and freedom to undertake a critique of medical practice was the key to the identification of crucial moral dilemmas (often not articulated by their teachers and ignored in the curriculum), they lacked the experience and independence to identify appropriate lecturers, other than the teaching staff of their own institution. Moreover, it was increasingly recognized that because medicine was not practised in a vacuum, members of other professional disciplines could make a significant contribution, and these were mostly unknown to medical students. This led to the establishment of a multidisciplinary Consultative Council of senior advisers, a radical move, because its members were charged with the sole task of identifying the most appropriate lecturers for the topics chosen by students, but without power to veto topics.¹⁸⁶

¹⁸⁴ *Hansard* (25 March 1969) 300: Col. 1165. See also Shotter (1969).

¹⁸⁵ Anonymous (1979).

¹⁸⁶ I remember that *Private Eye* described the Consultative Council as 'the conservative Council of the London Medical Group'.

In this way, the medical group method evolved, and was replicated in the groups formed elsewhere: a student critique of medical practice in which topics were identified by clinical students, and lecturers were suggested by senior advisers. A further refinement in London was that consultants were not invited to speak in their own hospitals, thus allowing controversial issues to be discussed without personal innuendo or rancour.

The role of medical student reps was not limited to identifying topics. They were responsible for all the logistics of the exercise in their own teaching hospital: booking lecture theatres – ‘Think of a number and choose somewhere too small’ became the received wisdom, as it was good publicity to have to move to a larger venue and bad publicity vice versa; displaying posters; distributing lecture lists; arranging projection facilities; and meeting and entertaining speakers 30 minutes before the start, during which they were briefed as to the format of the proceedings and the need to keep to strict timing if there was to be a full half-hour for discussion from the floor.

Dame Cicely had a unique overview of the LMG, lecturing annually from its inception until, as she put it, she ‘drew stumps after 25 years’. She noted:

Ted Shotter himself always managed to enable the committee to take charge, yet gave essential back-up, as he did with the whole exercise.¹⁸⁷

The role of the LMG Director of Studies (or Co-ordinating Secretary, in the case of other Medical Groups) was to synthesize the topics suggested by students with the advice about appropriate lecturers offered by the Consultative Council and then to encapsulate this in a thought-provoking, even provocative, title. Having no membership, medical group lectures and symposia had to attract audiences by their own merit, by the appositeness of the topics and the reputation of the speakers. Titles had to be sufficiently accurate to ensure that no-one was seduced into attending a discussion which was so mundane that it would otherwise have been ignored and sufficiently provocative to produce an audience.

In the case of the LMG, the Director of Studies was responsible not only for the production of the annual lecture list, which was a six-month task in itself, but also for the arranging, with a student convenor, of a series of Study Seminars or small tutorial groups; advising Cumberland Lodge in Windsor Great Park on its annual residential medical students weekend conference; and arranging with the Centre Laennec in Paris, biannual Anglo–French weekend conferences, held

¹⁸⁷ See Appendix 2, pages 118–21.

alternately in Paris and London each November and April. The Anglo-French weekend conference was open to an equal number of French and British medical students, who took part in ward rounds in each other's hospitals, attended a Carrefour on a chosen topic – the French requested 'control of pain' at St Christopher's Hospice or 'sexually transmitted diseases' at James Pringle House – these occasions served to illustrate the different culture of medical education in the two countries. They also served to highlight a particular aspect of the detailed organization of the conferences by the LMG, which the French referred to, initially, as 'la planification LMG,' but subsequently and more pointedly as 'la dictature'.

In point of fact, the LMG could not have functioned effectively without single-minded direction, which insisted that it was not a membership society, that it must always be topic-centered and must therefore eschew all social activities indulged in for their own sake, while admitting (promoting, even) social exchange in the context of its work: hence the pre-conference briefing dinner for speakers and chairmen of sessions and principal student officers; and the dinner following symposia and lectures, where the lecturers were entertained by the student reps from the host hospital.

The role of the student President, apart from chairing meetings of the Representative Council and Executive and attending the Governing Body, was to convene the annual conference. Shortly after being elected, the President and the Director of Studies would begin a series of weekly meetings – usually at 7.30am over breakfast, designed to fit in before getting to the hospital – at which the President's tentative idea of topic was explored and suggestions made of appropriate consultants and leading figures in other disciplines to approach for advice. Each week progress was reviewed until, over a period of two or three months, the conference title emerged and the subject matter and the two dozen or so speakers and chairmen of sessions identified:

Creating the conference was still one of the most rewarding and challenging things I have done. I still think of 'Iatrogenic disease' as a very good conference and tremendous to hear Ivan Illich and the other panoply of stars.¹⁸⁸

The vital ability of LMG representatives to inform medical students of forthcoming LMG events was demonstrated. Within a fortnight of the conference being announced, it was oversubscribed, as in previous

¹⁸⁸ John Sedgwick, President, 1974/5, from the response to the questionnaire.

years. The audience was composed of 300 students and 100 professional participants. And was limited only by the size of the hall. Before the conference, however, we received many irate telephone calls from non-medical people who insisted that they must come to the ‘Illich’ meeting.¹⁸⁹

The convenor of the 1977 conference wrote:

The Annual Conference is an opportunity to discuss a particular topic in greater depth than is possible in lectures and symposia. The two days of its duration are ideal for the multidisciplinary approach that characterises the LMG’s activities.

This year’s conference, entitled simply ‘Human sexuality’, aimed to examine past and present attitudes to sex and how they influence our personal and professional relationships.

For the past eight years LMG conferences have been oversubscribed, and this year was no exception. Applications started arriving by post from the moment tickets went on sale. We were thus rather surprised when LMG representatives reported difficulty in obtaining applications from their own colleagues. It seems that applicants were reluctant to admit any gaps in their sex education to their friends, but were well-prepared to write in by post: it was disappointing that so few nurses attended.

One of the prevailing themes of the Conference was the importance of the individual’s understanding of his own sexuality. This is crucial for the establishment of an honest professional relationship, particularly with the patient who has sexual problems.¹⁹⁰

Students		Qualified	
Medical	224	Doctors	37
Nursing	8	Nurses	12
Social Work	2	Social Workers	21
Theology	24	Clergy	12
Others	31	Others	30
Total	289 (72%)	Total	112 (28%)

Table 2: Attendance at the LMG conference, ‘Human Sexuality’, held at the Royal College of Surgeons on 11–12 February, 1977.

¹⁸⁹ John Sedgwick in the *Annual Report 1974/5*: 7.

¹⁹⁰ Dorian Haskard in the *Annual Report 1976/7*: 1.

Student participation

Initially, a student chaired both lectures and symposia, but it soon became clear that while the former presented no problems at all, control of senior clinicians in animated discussion required skills not yet acquired. Thus it was that, while lectures continued to be chaired by a student, symposia came to be chaired usually by a consultant from the host hospital, introduced by a student. This turned out to have sundry and surprising advantages, such as the discovery of private dining rooms, and other refreshing facilities, hitherto unknown to students. This was important, because another function of the student reps was to entertain the speakers to dinner afterwards. ('A privilege' frequently recalled by former Reps when responding to the questionnaire.) It seems that this development more or less coincided with the demise of the 'Firm Dinner', which had enabled teacher and taught to meet each other in a social context. Again, Cicely Saunders has memories 'of the cheerful and challenging dinners...which were very welcome honoraria, as the restaurants were always well-chosen'.¹⁹¹ Conversation over dinner became part of the student critique of medicine, often leading to refinements of topics which might be proposed for the following year.

The LMG did not claim to teach medical ethics but defined its purpose as 'the study of issues raised by the practice of medicine',¹⁹² which concern other disciplines, an approach endorsed by *The Times* Medical Correspondent when reviewing *Ethics in Medical Progress*, a report published in 1966 by the Ciba Foundation:

Almost imperceptibly, medical progress has posed the community with problems which will need all the skill of lawyers, moralists and theologians if the dignity of human life is to be maintained.¹⁹³

'The greatest objection': clergy

The role of clergy in the development of the study of medical ethics in Britain was not limited to the London group. In the case of the LMG, it stemmed from the SCM's commitment to dialogue with the academic world, and the appointment

¹⁹¹ See Appendix 2, pages 118–21.

¹⁹² 'The LMG is a non-partisan student group for the study of issues raised by the practice of medicine which concern other disciplines such as law, moral philosophy, moral theology and the social sciences'. From the final LMG lecture list, 1988/9.

¹⁹³ *The Times*, 7 December 1966. See also Wolstenholme and O'Connor (eds) (1966).

of one of its staff to follow up a report on medical education. Edinburgh was chosen for the second medical group solely because Kenneth Boyd, a Church of Scotland minister, also associated with the SCM, was identified as an inaugural Coordinating Secretary for the EMG, together with Alastair Campbell, another Church of Scotland minister. Newcastle and Glasgow followed suit with, respectively, Anglican and Roman Catholic university chaplains as coordinating secretaries.

It was, however, to prove fortuitous that the first Medical Group to be formed outside London was in Scotland, for no one in Edinburgh was prepared to be a branch of an organization in London: while accepting the title ‘Medical Group’ and the method pioneered by the LMG, the Edinburgh Medical Group insisted that it was autonomous and thus ensured the cellular structure of the subsequent organization of independent medical groups.

Aberdeen Medical Group is *an autonomous multidisciplinary student group* to explore and discuss issues raised by the practice of medicine which concern other disciplines...has no members...is independent of other groups in Edinburgh, Glasgow, Newcastle...is run by a multidisciplinary student Representative Council who select the topics for discussion.¹⁹⁴

The Birmingham Medical Group is an independent non-partisan student group without formal membership, which is concerned with the study of issues raised by the practice of medicine which also involve ethical, social and legal considerations beyond the scope of formal teaching curricula...by means of lectures and symposia which allow audience participation...uses a Consultative Council to provide continuity and advice and a Representative Council to suggest topics, arrange and publicise meetings.¹⁹⁵

The need for impartiality

However, if the medical groups were to achieve their objective, it was soon recognized as essential that they were seen as non-partisan and independent of all interest groups and lobbies and, consequently, in 1966, the ending of the link with the SCM was welcomed as ensuring the neutrality of the LMG and the proposed sponsorship by the Institute of Religion and Medicine rejected

¹⁹⁴ Aberdeen Medical Group lecture list, 1979/80.

¹⁹⁵ Birmingham Medical Group lecture list, 1977/8.

and a Governing Body, chaired by Lord Amulree, was set up. Equally it became clear that coordinating secretaries should in future be medically qualified, a role undertaken by Dr Kenneth Calman (Glasgow), Dr Liam Donaldson (Leicester) and Mr Sam Galbraith (Glasgow). Soon, former student reps, having qualified, were to take on this role: Dr Martin Brueton (Birmingham), Dr Jane Edgcumbe (Aberdeen), Dr Martin Hayes-Allen (Sheffield) and Dr Peter Wilkinson (Bristol) had all been LMG reps, while Dr Andrew Fraser (Aberdeen) and Dr Phil Cotton (Glasgow) were to become coordinating secretaries, having previously been local reps. Inevitably, however, the fact that the LMG was directed by a university chaplain caused some, erroneously, to see it as a religious exercise: ‘The greatest objection to the London Medical Group,’ said Professor W S Peart [Sir Stanley from 1985] of St Mary’s Hospital ‘is Father Shotter’; nevertheless agreeing to serve on its Governing Body. On the other hand, when at a meeting at the Royal College of Physicians (RCP), the LMG was described as a religious organization, Lord Rosenheim [President of the RCP], is reported to have replied, ‘I’m on its Governing Body; so it can’t be.’

It is worth noting that a similar pattern can be observed in the evolution of the *JME*, whose first Editor was Alastair Campbell, a moral theologian on the staff of New College, Edinburgh, editor of *Contact*, a journal of pastoral care, already lecturing on ethics for the Royal College of Nursing in Scotland and associated with the Edinburgh Medical Group. Although the editorship had been advertised, none of the medical applicants was deemed impartial and, at the suggestion of the chairman of the selection panel, Professor Archie Duncan, Alastair Campbell was telephoned and asked whether he would accept the editorial chair. But the second editor, Raanan Gillon, who was to hold the post for 20 years, was medically qualified, with a degree in philosophy, who had worked as a medical journalist. That he was also Jewish and an atheist seemed to me ‘a Godsend’.¹⁹⁶

One unremarked benefit derived from the involvement of clergy was their experience of using volunteers. As a result, there was no charge for attendance at lectures, symposia and study seminars. No fee was paid to lecturers, eventually some 200 per annum in London, although dinner was appreciated in lieu of an honorarium.¹⁹⁷ Nor was a fee sought, when responding to increasingly frequent requests for advice from broadcasters and journalists. Initially, therefore, the

¹⁹⁶ Gillon (2005): 90.

¹⁹⁷ Cicely Saunders, 2004, Appendix 2, page 118.

only expenditure¹⁹⁸ was publicity and students shared the cost of entertaining the lecturers among themselves, although this was found to be too burdensome for the student pocket as the lecture list grew. Help first came, when the House Governor¹⁹⁹ of the London Hospital offered to meet the cost of entertaining speakers after LMG symposia held in that hospital. The LMG and almost all the early medical groups started without any guaranteed up-front funding. And the conference fee was originally introduced only to ensure that those who had indicated that they would attend, did so.²⁰⁰

‘A pincer movement on the profession’: the influence of the medical groups on medical education

The *British Journal of Medical Education* reported in 1970 that:

There was no formal teaching on moral problems in medical schools and discussions on ward rounds are necessarily very limited.²⁰¹

And that many physicians and surgeons felt that their own training was inadequate on this subject.

Moreover, during the period 1960–70, when there was an increase of 50 per cent in the total number of citations in *Index Medicus*, there was a 300 per cent increase in those devoted to medico–moral questions. Despite this, the Royal Commission on Medical Education, meeting between 1965 and 1968, to which the LMG had given both written and oral evidence in 1967, failed to address this aspect of medical education and made no recommendations in its report.²⁰²

Norman Beale, St Mary’s Hospital Medical School and LMG President, 1970/1, wrote in the Annual Report for that year that the current LMG lecture list included all those topics, according to *Index Medicus*, which were continuing to attract interest.²⁰³ It was increasingly recognized that the LMG filled ‘a

¹⁹⁸ See Section ‘Financing the LMG’, page 102.

¹⁹⁹ The Hon. Mr Scarlett.

²⁰⁰ The fee at the final LMG Annual Conference on ‘AIDS, Sex and Death’, held at the Royal College of Surgeons of England, London, in February 1989 was £40 with refreshments including lunch and £10 for students and nurses within three years of qualifying.

²⁰¹ Pless (1967).

²⁰² Royal Commission on Medical Education (1968) See also Figure 12, page 68.

²⁰³ Beale (1971): 9–10, including graph and table.

recognized gap’ in medical education, and was ‘a conspectus of all that is good in British medicine’.²⁰⁴

But there was opposition to taking morals into the curriculum. John Rowan Wilson wrote:

One can imagine what it would be like if one particular consultant on the academic staff were detailed to give a series of lectures on the ethical aspects of medicine. He would sound either so sanctimonious that the students would detest him or he would sit on the fence so heavily that the iron would enter into his perineum.²⁰⁵

He added that the LMG seemed to have a reasonable answer. By bringing in speakers from other hospitals and facing difficult questions by lively discussion, rather than by formal teaching, the LMG was making an important contribution to medical education.

Influencing the GMC

That this was recognized by the GMC was made clear in 1984 when the Society for the Study of Medical Ethics (SSME) was invited to give a paper at the GMC’s conference on the teaching of medical ethics. Speaking on behalf of the SSME, which had developed out of the LMG’s Postgraduate Advisory Group of former student reps, I noted that:

Medical Ethics is no longer the preserve of the medical profession. It is SSME’s view that medical ethics is a multidisciplinary subject, which can benefit from the insights of disciplines other than medicine itself.

Medical ethics, in our view, goes beyond etiquette and codes, to a study of moral values and their application in clinical practice. Teaching should not aim to inculcate a particular moral viewpoint. Rather, medical ethics should be a critical study of the kinds of moral reasoning which lead doctors to different conclusions in medical practice.

We recognize that this view of medical ethics is increasingly, but not universally, held.

We believe that teaching should not be the sole responsibility of those who might feel morally bound to express their own views – to the exclusion

²⁰⁴ Amulree (1968): Foreword. In the view of Dr R D Catterall, as I recall.

²⁰⁵ Wilson (1970): 60.

of all others. Medical ethics teaching, because of its nature, could easily be exploited by lobbies or pressure groups – whether medical, religious or political. Indeed, fear that some might exploit the subject, whether wittingly or not, has led others to conclude that there should, or could, be no formal teaching of medical ethics at all.

Some who advocate this latter view claim that students could (and, in fact, do) gain an understanding of medical ethics throughout the whole course of their training, by a process of osmosis or by ‘picking it up on ward-rounds.’

There has been a notable contribution to the discussion of medico–moral questions by distinguished academics who are themselves not medically qualified – philosophers, lawyers, social scientists and moral theologians.²⁰⁶ Not all have been as provocative as Ian Kennedy’s Reith Lectures, but several have made major contributions to governmental and professional reports as well as to working parties concerned with fundamental medico–moral issues – such as those inaugurated by the Ciba Foundation.

At the same time as these multidisciplinary studies, a significant student interest has emerged in the promotion of...medical groups.... Albeit on an informal basis, a large cross-section of medical school staff is involved – 150 consultants and others in London alone each year. Indeed, in one medical school at least, Edinburgh, this has led to the Medical Group itself being invited to undertake teaching in curriculum time. The Leicester Medical Group has recently organized a first medico–moral case conference and others are planned. At the Westminster Hospital, LMG representatives have arranged the first Ethical Grand Round.

By far the most important element in the medical groups is the level of student participation and the way in which this is related to multidisciplinary advice. The topics included in the LMG programme are based on a student critique of medical practice, undertaken with

²⁰⁶ Lecturers in philosophy who were appointed to lectureships in medical schools include John Harris and Len Doyal, both of whom were given chairs (in Manchester and at Bart’s, London), while one former university chaplain, Kenneth Boyd, holds a chair in Edinburgh, and another, Alastair Campbell, at Bristol [since August 2006 at the Yong Loo Lin School of Medicine, National University of Singapore]. Two medically-qualified holders of chairs in medical ethics are Raanan Gillon (Imperial College, London, and editor, *JME*, 1980–2001) and Tony Hope (Oxford).

no senior advice or pressure, as to the choice of subjects, but aided by a multidisciplinary council to help identify the most appropriate lecturers – a process described, I think by Max Rosenheim as ‘a pincer movement on the profession by its cadets and senators’. (An) advantage of the method is that each year’s lecture list is a reflection of developments in medical practice, medical education and popular attitudes, rather than a static curriculum in ethics.

There are those who argue, however, that the success of the medical groups has actually hindered the development of the teaching of medical ethics in this country. Certainly, there has been no development in Britain comparable to the appointment of full-time ‘ethicists’ (their word), largely philosophers and theologians, in most American medical schools.

One of the difficulties of multidisciplinary studies is to ensure a balance between members of different disciplines. We all tend to be over-laudatory when talking of members of other professions – and hopelessly critical of members of our own: the nearest chaplain is almost by definition the wrong person – but so is the nearest doctor. Experience is required if an imbalance is to be avoided. One source of such experience is to be found in the local medical group.

In the light of the increasing demands for medical ethics teaching, and in the face of a diversity of opinion about how the subject might be taught, the Society for the Study of Medical Ethics has recently appointed a Working Party under the chairmanship of Sir Desmond Pond²⁰⁷ to examine alternative possibilities for the teaching of medical ethics.

However, the LMG itself was unsure about the appointment of lecturers in medical ethics in each medical school:

The adoption of the title ‘ethicist’, despite the fact that there is no common academic training, seems to indicate that there is a pseudo profession in the making. In Britain the neologism ‘ethicist’ should be rejected. It does not indicate a moral philosopher qualified to teach medical ethics but seeks to professionalize something which ought to remain an interdisciplinary dialogue.²⁰⁸

²⁰⁷ Boyd (ed.) (1987).

²⁰⁸ Unpublished speech to the General Medical Council, 1984.

Towards a wider audience

At home

towards the end of the 1960s, I began receiving invitations to lecture,²⁰⁹ although it became clear to me that describing the work of the LMG was no substitute for clinicians addressing the moral dilemmas of their practice. The scope and scale of the LMG lectures and symposia and the names of the lecturers began to interest publishers. A collection of papers by authors who had lectured under the auspices of the LMG on subjects ranging from the nature and management of terminal pain to organ transplantation, was published as a paperback.²¹⁰ Despite being described by a reviewer as a ‘stimulating volume,’ the publisher’s claim that it was the first of a series was not fulfilled. In any case, this first venture into the written word did not match, in my opinion, the excellence of the spoken word achieved by those who lectured for the LMG. But other forays into public discussion were to follow.

And abroad

In 1967, I was invited to lecture in Italy and in 1968 in Romania.²¹¹ A paper on the work of the LMG was given in Bucharest to an audience of theological students, members of the faculty and representatives of the Ministry of Cults, which reviewed some of the topics selected by medical students against the background of contemporary social concerns and legislation in the UK: abortion law reform, the decriminalization of homosexual relations and the problems of drug abuse. Afterwards, I was told by the former Rector of the Institute that this paper had opened the windows, while the then holder of that office said that it had ‘discussed problems which did not exist in a socialist republic’. Later, when asked over lunch by the British Ambassador,²¹² to describe the content of my lecture, I was interrupted by the Ambassador’s wife who ‘did not think these things were discussed at table’.

²⁰⁹ Cambridge, 14 May 1968; London, 15 May 1968; Peterhouse College, Cambridge, 24 January 1971; Oxford, 13 November 1971; Gloucester, 10 March 1983.

²¹⁰ Shotter (ed.) (1970).

²¹¹ In Italy, at the Sacro Cuore Faculty of Medicine, Rome, 4 April 1967. This was followed by an audience with Pope Paul VI, who thought working with medical students was ‘very difficult’. In Romania, at the Institute of Theology, Bucharest, 18 April 1968.

²¹² Sir John Chadwick KCMG (1911–87) was a member of HM Diplomatic Service from 1938 to 1971, and Ambassador to Romania, 1967/8.

This lecture led to LMG rep, Neal Killala, St Mary's Hospital Medical School, undertaking an elective period in 1969 in Bucharest and to meetings with several clinicians, including Professor Ovidiu Marina, and Dr Ana Aslan, who claimed that Procaine induces longevity.²¹³ Professor Marina was author of an officially approved handbook of medical ethics, and must have been aware that Nicolae Ceaușescu, in his collected works, held that the doctors should have same ethics as the workers.

In church

In 1976, Dr Gordon Wolstenholme, Director of the Ciba Foundation, invited the Archbishop of Canterbury, Dr Donald Coggan, to give the Edwin Stevens Lecture to the Royal Society of Medicine. Being led to understand that he had invited the wrong archbishop (John Habgood, the Archbishop of York, had trained as a biochemist), he asked me to prepare a brief for Lambeth Palace in order to give a steer to the lecture. This idea was initially rejected by the Primate's staff. ('The Archbishop writes his own speeches.') However, after an amount of lobbying in certain quarters, I was told to submit a paper for Dr Coggan's consideration. In it, I advised that:

There was a need for a major statement, drawing attention to the marked similarity between the conclusions which derive from the theological doctrine of Ordinary and Extraordinary Means (contained in the Papal Allocution of Pius XII to a congress of anaesthetists regarding the use of artificial respiration),²¹⁴ the English Common Law Doctrine of Necessity²¹⁵ and the position of the Church of England following the recent debate on euthanasia in the General Synod. The circumstances of the death of Franco and the immense publicity surrounding the Quinlan case, had resulted in a widely held opinion that Roman Catholic teaching is that life should be maintained at all costs; ironically, it was the doctors, not the priest, who gave this advice to the Quinlan

²¹³ Professor Ovidiu Marina was Professor of Experimental Surgery, Fundeni Hospital, Bucharest. Professor Dr Ana Aslan, is a gerontologist, founder and General Director of the State Institute for Geriatric Research and Geriatric Medicine in Bucharest, Romania, and was much celebrated by the communist regime.

²¹⁴ Church of England, Board for Social Responsibility (1965b): 52. Quoted in Appendix 3.

²¹⁵ Church of England, Board for Social Responsibility (1965b): 49. Quoted in Appendix 2, by Chancellor E Garth Moore.

family.²¹⁶ Again, despite the publicity given to the report *On Dying Well* there remained a popular belief that most Christians were in favour of the artificial prolongation of life under all circumstances. This may not be shared by a well-informed minority of doctors and nurses, but it is clear that a majority of members of the medical profession are not well informed on these matters....Nothing could be more valuable at this time than to have a statement from the Archbishop of Canterbury, underlining the identity of opinion which is shared by the Church of England, the Church of Rome, the English Common Law and the traditional medical ethic of ‘not striving officiously to keep alive’. If it were realised that such a consensus existed, it would correct a widely-held and dangerous misapprehension that the Church teaches that life should be sustained under all circumstances;...enhance the care of the dying and go some way to restoring popular confidence in the medical profession (after Franco). A Note of Caution: it is important not to assimilate discussion of prolongation of life (or of euthanasia) to the abortion issue. It is this which has led to the popular idea that those who do not oppose abortion necessarily support euthanasia.²¹⁷

The resulting lecture, which had clearly adopted the brief, (albeit with some additional economic considerations which proved controversial), received national coverage in the daily press, with front page headlines and editorial comment on 14 December 1976 and in various provincial papers.²¹⁸ Extracts from the lecture were carried by the *JME* together with a favourable editorial, while the text appeared in the *Journal of the Royal Society of Medicine*, and the Royal Society of Medicine published it as a monograph.²¹⁹

²¹⁶ Karen Ann Quinlan (1954–1985) was 21 when she became unconscious after a party in New Jersey in 1975 and drifted into a persistent vegetative state. After several months on a ventilator, her parents asked the hospital to stop active care, which was refused. The subsequent case set legal precedents, but also involved religious principles because she and her family were Catholics. Quinlan was removed from active life support in 1976, but lived in a coma until her death from pneumonia in 1985.

²¹⁷ Shotter (1976).

²¹⁸ In *The Times*, *Daily Telegraph*, *Guardian*, *Daily Mail*, *Daily Express*, *Daily Mirror*, *Church Times*, *Universe*, *Catholic Herald* and *The Sunday Times*.

²¹⁹ Coggan (1977a, b and c). See also Saunders (1977) and Clark (1998, 1999).

The *Daily Telegraph* commented:

Even an Archbishop of Canterbury cannot expect to find anything wholly new to say about death. Nevertheless, Dr Coggan's address on that subject to the Royal Society of Medicine last night was outstanding both in its intellectual clarity and in the depth of spiritual insight and pastoral wisdom which it displayed.

while the *Daily Mail* headlined:

The Primate provokes controversy over doctors' duty to the dying

When is it right to end a life?

which was mirrored by *The Sun*:

Primate: When to let the sick die

***The Sun* says Wise words**

The Archbishop of Canterbury, Dr Donald Coggan, was right to speak out yesterday on the tragic subject of the terminally ill. His wise and humane advice is that there is no moral obligation to keep people alive artificially.

Dr Cicely Saunders was reported in the *Church Times* as saying,

I am terribly glad to have a statement like this from a Christian leader. I think the Archbishop...has shown courage to step into this difficult area. The problems illustrate how difficult it would be to bring the law into this.

The British Medical Association (BMA) found the Archbishop's lecture helpful 'because it emphasised the difficulties faced every day by doctors and clergymen.' It welcomed Dr Coggan's 'words of support' in what a spokesman described as 'a very difficult area'.²²⁰

However, one editorial commented:

The overwhelming majority of people will agree with the Archbishop that the artificial prolongation of life – as occurred in the case of General Franco – is distasteful and humiliating. But to make this point in the context of National Health housekeeping is puzzling to say the least.

²²⁰ *Church Times*, 17 December 1976.

Surely we do not want doctors responsible for terminally sick patients to consider Government and taxpayer as an equal duty.

Did Dr Coggan take advice before he prepared his speech? If so, the advice was ill-considered.²²¹

And state²²²

From 1969, the Queen made an annual donation to the London Medical Group, which has continued as support for the IME.²²³

Prince Philip, Duke of Edinburgh and Chancellor of the University of Edinburgh, became Patron of the Edinburgh Medical Group and chaired an EMG conference on Health and the Environment on 17 December 1971.²²⁴

Postgraduate developments

further evidence of a widening influence of the LMG came when I was invited by Dr Wolstenholme to chair a sub-committee of the Society of Apothecaries with the intention of introducing medical ethics into the Society's Faculty of the History of Medicine, reconstituted as a Faculty of the History and Philosophy of Medicine. Whereas the course leading to a Diploma in the history of medicine appeared to have been conducted by interested amateurs, it was recommended that someone qualified to teach ethics at university level should be appointed lecturer. The first eight Diplomas in the Philosophy of Medicine were awarded in 1980.²²⁵

²²¹ Unidentified press cutting.

²²² I became a Fellow of the Royal Society of Medicine by invitation in 1976, and, in 1977, a Prebendary (honorary canon) of St Paul's Cathedral, London.

²²³ Subsequently I was invited to lunch with the Queen and the Duke of Edinburgh on 20 May 1981.

²²⁴ Professor Kenneth Boyd donated an audio tape recording of the 1971 Edinburgh Medical Group conference, opened by Professor Michael Swann, Principal and Vice-Chancellor of University of Edinburgh (1965–73), with contributions from Professor R B Fisher on Biochemistry, Dr Aubrey Manning on Zoology, Professor Alastair Currie on Medicine and Dr Colin Currie from a junior doctor's perspective. These will be deposited along with the tapes and other records of the Witness Seminar in GC/253, Archives and Manuscripts, Wellcome Library, London.

²²⁵ Following a course delivered by Dr Michael Lockwood, Lecturer in Philosophy, at University College, Oxford.

A junior doctor initiative: The Society for the Study of Medical Ethics

The extension of the medical group method at a postgraduate level became the concern of junior hospital doctors, who as students had helped to pioneer the lectures and symposia of the LMG and who formed themselves into a Postgraduate Advisory Group under the chairmanship of Professor R B Welbourn. From this concern grew the Society for the Study of Medical Ethics in 1972, which aimed ‘to influence both professional and public discussion of the moral consequences of medical practice, to ensure that this developing subject achieved a proper autonomy and that multidisciplinary discussions were not unduly influenced by any one of the non-medical interests’:

Above all, to ensure in Britain, at least, the discussion of medico–moral dilemmas shall be based firmly in the realities of clinical practice.²²⁶

The first members

Following announcements in the *BMJ* and the *Lancet*, over 250 individuals and institutions made enquiries and, by November 1972, there were already over 100 ‘On dying and dying well’ members.

Documentation in Medical Ethics

The SSME determined from the start not to publish a journal but to try to secure the publication of papers in the medical journals. It had, however, invited individual membership, the principal benefit of which was receipt of *Documentation in Medical Ethics*, a folder of off-prints, reprints and original papers.

Edited largely by junior doctors, the editorials of the first issues of *Documentation* reveal the developing concerns of the Society.²²⁷ The editorial of *Documentation* No. 1 sets out the Society’s modus operandi and records a determination not to add another journal to the medical scene:

In fact such a journal confined to new original contributions defeats our purpose. *Documentation* sets out to provide a background of readings in medical ethics and associated issues raised through the practice of medicine. The sources of our discussion are wide and varied, and to be just we must be prepared to read beyond the exclusively medical journals.

²²⁶ Anonymous (1972).

²²⁷ Dr Roger Higgs and Dr Anthony Thorley.

Documentation aimed to be interactive:

We hope members will use the enclosed postcard to advise us about past articles which are considered important and valid.

And balanced:

This first issue sets the pattern for the future. The subject matter is broadly based, and yet when specific issues are dealt with in detail it is intended to present a balanced view in the manner of the jointly sponsored SSME/LMG conference on ‘The problem of euthanasia’. SSME can see no value in being identified with any lobby or pressure group over controversial issues, for where bias emerges discussion ceases, and *Documentation* seeks to reflect and monitor responsible opinion from all sides.

Traditionally the doctor tends to disregard the non-medical contribution to medical ethics, stating in strong terms that it is he alone who is concerned with the practical issue. Decisions are made, but we are largely unaware how we make them and we have much to find out. If we are to begin to understand how and why we go about our moral judgements we must learn from the moral philosopher of the process and logic of decision making, and relate this to our own personal inconsistencies in the clinical situation. Similarly we must examine the contribution that can be made by the lawyer and sociologist. The practitioner and theoretician must be prepared to learn from each other, and each learn from the experience of the patient. We may hope that out of this kind of interaction and discussion will come a synthesis of ideas and an understanding of principles that will be a first stage towards an established philosophy of medicine.²²⁸

Publish and be damned?

Just over a year later, the editorial of *Documentation* recorded a change of strategy:

Most important (and contrary to the intentions of those who inaugurated the Society) it has been decided to launch a *Journal*. This will appear quarterly from January 1975 and will become the principal benefit of membership. It will aim to go beyond the merely subjective discussion

²²⁸ *Documentation in Medical Ethics*, No. 1, November 1972.

of issues raised through the practice of medicine and will try to combine *clinical* and *conceptual* analysis of medico–moral problems. It will not be the mouthpiece of any establishment; but will not ignore the insights of other disciplines. It will seek to disentangle ethics from etiquette and will aim to build up a body of knowledge in this field. In seeking to reflect opinion both inside and outside the medical profession, it will not inhibit expression of opinions which might ‘give a lead’ to others.²²⁹

The *Journal of Medical Ethics*

The conception of *JME*

No reason was offered for this abrupt reversal of policy. However, the present writer was present at the discussions which lay behind it, and can recall some of the background to this decision. Firstly, there was the fact that SSME, having developed out of the LMG’s Postgraduate Advisory Group, relied upon the small secretariat of the LMG to service its membership and it soon became clear that compiling *Documentation* was labour-intensive: if the LMG itself was not to be impaired, another solution must be sought. Secondly, *The Times* had carried a report ‘Bavarian doctor admits to 30 or 40 cases of euthanasia’. This appeared to describe good control of pain that may well have shortened life. On the basis of the 1972 LMG annual conference on the ‘Problem of Euthanasia’, a letter, signed by Lord Amulree and Professor Welbourn was published in *The Times*, under the heading ‘Control of pain is not euthanasia’.²³⁰ This produced a private response from Sir Cyril and Mr Ernest Kleinwort, the Merchant Bankers. At a subsequent meeting, over lunch, Ernest Kleinwort described how a colleague in Kleinwort Benson Lonsdale in New York had been kept alive artificially, to the great distress of his family and friends. The Kleinwort brothers were about to retain the services of a retired surgeon and intended to pamphleteer doctors on this single issue. When it was suggested that this was a good way of filling the medical waste-paper baskets of Britain, a lively discussion ensued, in which the work of the SSME and the medical groups was described and which led to Ernest Kleinwort’s asking ‘How can we help?’ – to which I replied that they could help launch a journal of medical ethics. It was agreed, there and then, that the advice of the *BMJ* should be sought as to format and costings and that we should report back to the Kleinworts. It was decided that such a journal should look and feel like a medical specialty journal and, at Dick Welbourn’s suggestion, should be modelled on *Gut*.

²²⁹ *Documentation in Medical Ethics*, No. 2, December 1973.

²³⁰ Letter to *The Times*.

Gestation

Figures provided by the *BMJ* suggested that, if SSME were to launch a new journal, it would require a sum of £10 000 a year for three years and this information was communicated to Ernest Kleinwort. At a further meeting, SSME was offered £10 000 a year for two years. To the response that this was not enough: 50 per cent more was required, Ernest Kleinwort replied ‘£15 000’ while I said, ‘For three years’. To which Ernest Kleinwort responded, ‘That’s £45 000: I must tell my brother about that’. ‘This,’ said Dick Welbourn, ‘is serendipity’. In the event, £45 000 over three years was offered jointly from the Ernest Kleinwort Charitable Trust and the Sir Cyril Kleinwort Charitable Settlement, sources of funding which were to underwrite the journal until it became commercially viable.

Paternity?

It soon became clear that Ernest Kleinwort would be no sleeping partner. Frequent telephone calls asking for progress reports (and complaining of the time it was taking to set up the journal), made it clear that a place must be found for him in the Society. To the question, ‘Would Mr Kleinwort accept an invitation to chair the Finance and General Purposes (F&GP) Committee?’ there was a positive response. But there was no F&GP. It had to be set up in order to accommodate this most enthusiastic benefactor.

Serendipity

At that time the SSME was operating out of the LMG’s office in the basement of 103 Gower Street. Under Ernest Kleinwort’s chairmanship of the F&GP Committee, a suite of offices was rented, and fully kitted out, in Tavistock House (part of BMA House), Tavistock Square, chosen because the *Journal* was to be marketed and managed by Scientific and Professional Publications – a *BMJ* imprint.²³¹ It was also ideally located, close to mainline railway stations and equally accessible from most of the London teaching hospitals. Having sorted out office accommodation, he went on to enquire about the Director’s remuneration. When told, he said that he did not know that people were paid so little. As a result the University of London lecturer scale was adopted, with the bar removed, in time rising to the non-clinical professorial average.

²³¹ The offices remained in Tavistock Square until 1988, when a rent increase coincided with reduced financial support for the LMG. Subsequently, rent-free accommodation was provided in Cavendish Square, through the good offices of Brendan Callaghan, and the generosity of Heythrop College, University of London.

Following the death of Ernest Kleinwort, in 1976, his brother Sir Cyril became Chairman of the F&GP, being succeeded in 1979 by Lord Limerick, also a Kleinwort merchant banker, who continued in the chair for over ten years.

The birth of *JME*²³²

The appointment of Alastair Campbell as the first Editor is recorded elsewhere.²³³ Individual membership of SSME was withdrawn and existing membership fees were subsumed as subscriptions to the *JME*, which declared in its first editorial that:

The reputation of a newly-founded journal must be established by its style, quality and range of the material it offers' rather than by editorial policy statements, whilst noting that even the phrase 'medical ethics' can create misunderstandings and provoke suspicions (especially perhaps among medical readers).

The aim of the *Journal of Medical Ethics* is to provide a forum for the reasoned discussion of moral issues arising from the provision of medical care. It will hold no brief for one particular professional, political or religious viewpoint. The articles it publishes will identify current problems, present factual information, and clarify different moral assumptions. To fulfil these aims the Editors can call on the resources of the disciplines of law, philosophy and theology, as well as on the whole range of medical and paramedical specialties....We will employ as many methods as possible to make the discussion of moral choices in medicine lively and informed.

Through the pages of the journal, and especially under the editorship of Raanan Gillon, the work initiated by the LMG was to reach a world-wide audience. With a readership equally divided between the UK, North America and the rest of the world, its growing circulation would be matched by greater frequency of

²³² The journal was launched at a press conference held at the Royal Society of Medicine on 23 April 1975 followed by a dinner given by Lord Amulree at the Reform Club. Among those present were: Lord Kilbrandon, Professor Sir Martin Roth, Sir Brian Windeyer, Professor W S Peart, Professor R Y Calne, Canon G R Dunstan, Professor R B Welbourn, Professor A S Duncan, Professor C M Fletcher, Mr John Sedgwick, Miss Gunilla Liddle and the Revd Edward Shotter.

²³³ See 'The need for impartiality' on page 85.

publication, until in 2005, 30 years after it was launched, it became a monthly publication and it was already most cited in its field.²³⁴

In 1981, the Annual Report noted:

The death of Sir Cyril Kleinwort signalled the end of a remarkable connection between the Society for the Study of Medical Ethics and the Kleinwort brothers. Sir Cyril and Ernest Kleinwort not only ensured that the *Journal of Medical Ethics* could be published at all but their generosity over the past eight years has exceeded £100 000. Their original intention was to launch the *Journal*, but they have in fact underwritten the London Medical Group for a number of years. Now that the *Journal* is largely self-financing, the support of their charitable trusts has come to an end.²³⁵

It was Ernest Kleinwort's intention that any profit from the *Journal* should be applied to the LMG.

Funding

The cost of communication

The fact that, for over 20 years, diverse bodies were prepared to provide financial support for the LMG, is itself evidence of its growing influence. However, from the start, the LMG was run on a shoestring. Initially, its only costs were publicity: the printing of posters and the annual lecture list. It was fortuitous that, from the outset, it was determined that the details of all lectures should be published in a lecture list (as the printed programme was called—there were only lectures in the first year, 1963/4; the first symposium appeared as the final event of the second year, 1965). However, there were no funds to employ a professional artist, so I drew the letters 'LMG' in Roman script, freehand, using a fountain pen, from which a reverse block was made, which was used throughout the life-span of the LMG, becoming a well-recognized trademark and which helped ensure continuity. Had posters been the only form of publicity, it is most unlikely that the LMG could have survived its initial years and become a recognizable entity. The lecture list was to become a potent

²³⁴ The product sheet for the *JME* claims it to be 'ranked second in the Medicine, Legal category of the Science Citation Index and is also listed in the Philosophy section of the Social Science Citation Index', with an impact factor of 1.312 (2005). See www.ovid.com/site/catalog/Journal/634.jsp?top=2&mid=3&bottom=7&subsection=12 (visited 15 May 2007).

²³⁵ *Annual Report 1980/1*: 5.

tool in promoting the programme to students and others: it fitted in a jacket pocket and could stand on a mantleshelf. It demanded attention and, with a five-year colour sequence, the latest list was readily recognized. The quality of its presentation was intended to reflect the quality of its content. Because it did not refer to medical ethics, or morals, or religion, there was nothing to inhibit interest and there was no barrier to examining its contents, ‘LMG? What’s that?’ (Some, with military experience, thought it might stand for ‘Light Machine Gun’.) It was sufficiently anonymous to invite enquiry. It was to become an important weapon in fund-raising and promoting medical groups elsewhere. And the programme was produced in quantity; typically a print run of 15 000 in October, with a further run of 10 000 the following January, containing more detailed advertising of the annual conference.

Financing the LMG

Initially, the SCM was prepared to meet the modest costs of the exercise: £60 on a budget of £40 in 1963/4; £100 on a budget of £60 in 1964/5. But by 1965/6, when the programme had grown to 21 lectures and symposia, costs had reached £1179 and it was agreed that the LMG must stand alone. Fund-raising became essential, if the exercise was to continue. A Governing Body was formed and, at the suggestion of Professor G R Dunstan, Lord Amulree agreed to become chairman (‘for three years, provided that it did not involve Fund-raising’ – it involved little else – and on condition that the President should be a student). The Governing Body appointed me as Director²³⁶ and agreed to pay such salary as I could secure. Lord Amulree continued as chairman until 1981, when he was succeeded by Professor R B Welbourn.

Never look for money: look for friends²³⁷

From 1 June 1966, on separation from the SCM, all the costs of the LMG had to be raised from charitable sources. Towards a budget of £2500 for the academic year 1966/7, the Goldsmiths’ Company made a grant of £250 – the first donation received. The Wemyss Foundation, a DuPont charitable trust, based in Wilmington, Delaware, made a grant to enable me to spend eight weeks visiting medical centres in the USA, in what proved to be a fruitless search for similar activity stateside, while the Ella Lyman Cabot Trust of Cambridge, Massachusetts, at the prompting of Cicely Saunders, made a personal payment

²³⁶ From 1972, Director of Studies.

²³⁷ The advice of Cicely Saunders.

of \$2000 to enable me to continue the work. By 1967/8, there was an income of £2882 which included grants of £1000 and £500 respectively from the St Edmund, King and Martyr Trust, in the City, and the Sir Halley Stewart Trust, again negotiated through the good offices of Cicely Saunders. None the less, at one point in 1967, it became clear that if a further sum of £700 were not secured, the LMG could not continue. Astonishingly, this sum was raised by David Lister, a solicitor, from 98 friends and acquaintances.²³⁸ And, as previously noted, during the following year, the Queen made a first annual donation, which continues as support for the Institute.

In 1968, the Dean of Windsor introduced me to Brigadier Patrick O'Brien Twohig, a fund-raising consultant, the cost of whose services was met by the generous assistance of Lord Beaumont of Whitley.²³⁹ The resultant appeal, launched on 10 April 1969, set out to raise £55 000 to cover 'expenses and development over the next seven years'.²⁴⁰

While the growing influence of the LMG was reflected in an ability to attract funds for new activities such as research and publication, the finances of the LMG itself, which depended inevitably on 'soft' funding, were to remain precarious. The Senior Treasurer's Report for 1975/6 records a total expenditure for the LMG of £14 656 against an income from grants of £8 646. Fortunately, however, the Society (whose accounts included those of the LMG):

showed a provisional income of £35 922, against an expenditure of £32 456. Thus it is evident that the LMG could not have survived without the Society, which developed from it. Without new sources of income it is impossible to contemplate the future with any certainty. We welcome, therefore, the fact that the Junior Treasurer has for the first time been able to attract financial support for the Annual Conference from pharmaceutical companies.

From 1976–79, my salary as Director of Studies was underwritten by a Leverhulme Senior Educational Fellowship 'to further the study of medical

²³⁸ For a list of donors, see Appendix 8.

²³⁹ The Rt Revd Robert Wilmer (Robin) Woods KCMG KCVO (1914–97) was Dean of Windsor, 1962–70; Domestic Chaplain to the Queen, 1962–70; Register of the Most Noble Order of the Garter, 1962–70; Bishop of Worcester, 1970–81 and Assistant Bishop, Diocese of Gloucester, from 1982 until his death in 1997.

²⁴⁰ The appeal had raised a total in cash and promises of £31 450 from 130 donors by June 1971, 96 of whom were individuals.

ethics'. By 1980, total expenditure had grown to £71 000, while at the start of the financial year only £55 000 had been secured, leaving £16 000 to be found from new sources.

However, by February 1981, when no additional grants had been secured, it became clear that there was no alternative to either a sudden injection of new funds, or an equally sudden curtailment of the activities of the LMG. In the event, only the generosity of the Ernest Kleinwort Charitable Trust, the Bernard Sunley Trust, and BUPA (the British United Provident Association), which made grants of £10 000, £5000 and £1000 respectively, enabled the work to continue.

The search for permanent funding

At this point, the King's Fund, which had supported the LMG since 1971, indicated that it viewed the LMG as sufficiently established to look for more permanent sources of income and it became clear that core funding would have to come from non-charitable sources. A small working group was set up to advise the LMG comprising Geoffrey Phalp²⁴¹ and Sir Douglas Ranger.²⁴² However, when an approach to the Conference of Metropolitan Deans, for half of the LMG's budget, yielded only £12 000 per annum, the DHSS was approached and undertook to review its annual grant of £5000 to the SSME.

The search for funding continued as activity and expenditure increased year on year. At the start of financial year 1981/2, there was an estimated expenditure of £113 406, towards which grants of £101 712 had been promised, leaving yet another shortfall of £11 694 to be found. However, between 1981 and 1989, it became possible to assimilate administrative costs to the burgeoning research programme.

To sell or not to sell?

But the problem was never fully resolved and when, in 1989, ethics was included in the medical schools' curriculum and I determined that the LMG should be wound up as a going concern, only the sale to the *BMJ* of a half share in the *Journal of Medical Ethics* would square the accounts and ensure the continuity of the Institute, now underwritten by its commercially viable journal.

²⁴¹ Dr Geoffrey Anderson Phalp CBE (1915–86) was Secretary of the King Edward's Hospital Fund for London, 1968–80.

²⁴² Sir Douglas Ranger Kt FRCS (1916–97) was Otolaryngologist at the Middlesex Hospital, 1950–82 and Dean of the Middlesex Hospital Medical School, 1974–83.

The development of the institute

What's in a name?

The Society for the Study of Medical Ethics became the Institute of Medical Ethics (IME) in 1984, prompting editorial comment in the *Journal*, which asked whether the change of name was of any interest to anybody other than printers of letterheads and compilers of directories:

Time will show but the *intention* is to mark an important development, already in process, of becoming a major national resource in medical ethics. So far the society has a reasonable record in stimulating and assisting others to promote the multidisciplinary study of medical ethics. Almost every British medical school has a student group similar to the London Medical Group. The society has also set up several multidisciplinary working groups. In 1975 the society founded this *Journal*....However, as awareness of and critical thinking (in both senses) about the problems of medical ethics become more widespread at various levels, the demands for assistance can be expected to continue to escalate, with the institute becoming the focus of more and more requests for information, ideas and advice. The media want some ethical background to the latest medico–moral story....Politicians, lawyers, clergy interested in pursuing some aspect of medical ethics ask – or ask their researchers to ask – for relevant information....However, the support which the society has been able to offer has necessarily been limited. The change of name indicates an ambition...to overcome these limitations and grow to meet the demands quite properly made upon it. Among the intentions of the institute are to provide by means of a bulletin regular synoptic information about what is going on in medical ethics.²⁴³

What the editorial does not disclose is that the decision to change the name was a pre-emptive strike, lest it should be adopted by a partisan interest group or lobby for a particular moral viewpoint. It was the same thinking that, 20 years earlier, had prompted the London Medical Group to register MEDETHIC as its telegraphic address.

By 1985 there was sufficient demand for a quick response to medico–moral questions for the *IME Bulletin* to be launched to ‘monitor and keep [subscribers] in touch with current developments and topical issues in medical ethics’. It also

²⁴³ Anonymous (1985b).

advertised ‘a regular series of Supplements’ to look at individual subjects in greater depth. Edited by Dr Richard Nicholson and backed by the Hon David Layton’s Incomes Data Services, it eventually separated from the Institute, renamed the *Bulletin of Medical Ethics* and was for a time published by the Royal Society of Medicine.²⁴⁴

Beginning in March 1989, and funded by the Leverhulme Trust, the Institute began publishing *Briefings in Medical Ethics*, to ‘provide a concise and impartial analysis of ethical problems that arise out of today’s medical practice’. Intended to be the Institute’s rapid reaction force, an early number responded to reports of the sale of kidneys for transplantation.

The recent announcement of an intended transplant operation using a kidney bought from a Turkish man met such widespread condemnation that the Government quickly introduced a Bill to prohibit such transactions.²⁴⁵

Research

the Institute’s research programme originated as the Edinburgh Medical Group’s Research Project in Medical Ethics and Education, which produced two reports in 1979: *The Ethics of Resource Allocation in Health Care* and *Dilemmas of Dying*, together with a paper on ‘Research ethical committees in Scotland’.²⁴⁶

The Edinburgh Medical Group had been established in 1967, to provide an independent and non-partisan forum for the interdisciplinary and multi-professional study and discussion of moral issues raised by the practice of medicine. Like the London Medical Group before it (and Medical Groups in most other British medical schools subsequently), it had been set up largely on student initiative; and its programme of lectures, symposia and conferences on relevant social and moral topics met an evident need, not only among students, but also among practitioners. In time, however, many of those who participated came to

²⁴⁴ The *Bulletin of Medical Ethics*, founded in 1985, is an independent publication providing current news, views and reviews on a wide range of issues in healthcare ethics and is edited by Dr Richard Nicholson. Subscribers to the journal include doctors, nurses, lawyers, research ethics committee members, academic institutions, journalists and lay people with an interest in healthcare ethics. See www.bullmedeth.info/ (visited 17 May 2007). Incomes Data Services is an independent research group providing pay data for employment-related fields.

²⁴⁵ *Briefings in Medical Ethics* 2 (1989).

²⁴⁶ Boyd (ed.) (1979); Thompson (ed.) (19779); Thompson *et al.* (1981b).

believe that it would be helpful if some of these topics could be examined in greater depth than was normally possible in the Edinburgh Medical Group programme. This request, in other words, was for some kind of research activity to complement and stimulate the growing educational role of the Edinburgh Medical Group. It was not immediately apparent, however, what kind of research was appropriate in this context, since conventional models, including the academic study of moral theory and the various social scientific options, were probably employed to the best effect in their respective disciplinary contexts. It was therefore only after extensive discussion, in Edinburgh and with the other Medical Groups, that the possibility of an appropriate form of research became apparent. This, it was agreed, would have to reflect the Edinburgh Medical Group's interdisciplinary and multi-professional interests, its involvement of informed lay opinion in its discussions, its concern with medical and nursing education, and above all its basic motivation as a body specifically concerned with moral issues in health care.

With these considerations in mind, the Edinburgh Medical Group and the University of Edinburgh proceeded in 1975 to set up a research project in medical ethics and education...funded by the Leverhulme Trust Fund and the Nuffield Provincial Hospitals Trust....The general rationale of the multi-professional working group method can also be briefly stated. It is...a traditional and reasonably straightforward way of investigating moral issues. It also, in fact, returns to the methods which the founding fathers of moral philosophy suggested for that discipline, and particularly to the methods of Socrates and Aristotle. Socrates' method was to ask critical questions of experts and to engage in rational debate, in the hope of establishing a public consensus about the issues and how to decide them...Aristotle argued that ethics should begin, not from abstract principles, but from the actual moral judgements of people with some experience of life. Its task, he believed was to seek, not mathematical precision (which was not in the nature of its subject matter), but general clarification of the issues in the interest of reaching some broad consensus for practical purposes...The method adopted by the Edinburgh Medical Group followed these general guidelines.²⁴⁷

Subsequently, in 1981, the Institute commissioned a study of the ethics of research on children, chaired by Professor G R Dunstan, with Dr Richard

²⁴⁷ Boyd (ed.) (1979).

Nicholson as research fellow, and funded by the Leverhulme Trust with a grant of £38 000 over two years.²⁴⁸ In 1983, the All Saints Educational Trust made a grant of £20 000 over two years for a study of consensus in medical ethics.²⁴⁹ In the following year, a grant of £33 000 was made by the Nuffield Foundation for a two-year study of methods of teaching medical ethics to medical students, which was chaired by Sir Desmond Pond and for which Kenneth Boyd was research fellow.²⁵⁰ A major study of the ethics of medical research involving animals, was supported by Leverhulme with a grant of £92 000 over three years, together with additional funding from a cross-section of interested bodies; this was chaired by Professor G R Dunstan, with Kenneth Boyd as research fellow.²⁵¹ In 1987, the King's Fund made a grant of £25 000 for a one-year study of ethics in nursing and nursing education.²⁵² In 1988, a Leverhulme grant of £128 000 over three years enabled the Institute to publish regular *Briefings in Medical Ethics*, a project chaired by Sir Douglas Black, with Kenneth Howse as research fellow. Small grants were received in 1989 from the Wellcome Foundation for a study of the ethical implications of AIDS, chaired by Sir Patrick Nairne and from the European Commission for a study of the ethics of medical involvement in torture, chaired by Sir Raymond Hoffenberg.²⁵³

A Working Party on the ethics of prolonging life and assisting death, chaired initially by the late Mr Geoffrey Drain, a former General Secretary of NALGO, led to a Scottish Office-funded study of six Neonatal Intensive Care Units in Scotland, for which the principal researcher was Hazel McHaffie.²⁵⁴

Reflections: 40 years on

It is over 40 years since the LMG began. Some of those involved as students have retired or are nearing retirement or have died and it was thought essential to record this innovatory exercise while there was first-hand experience to call

²⁴⁸ Nicholson (ed.) (1986).

²⁴⁹ Boyd *et al.* (1986).

²⁵⁰ Boyd (ed.) (1987).

²⁵¹ Smith and Boyd (eds) (1991).

²⁵² Gallagher and Boyd (eds) (1991).

²⁵³ Institute of Medical Ethics Working Party on the Ethical Implications of AIDS (1992); Hoffenberg (1993). See also Nairne (1993).

²⁵⁴ Drain (1990); McHaffie (1993); Campbell and McHaffie (1996); McHaffie and Fowle (1996, 1998, 2001).

upon. Moreover, the unique contribution made by the medical groups to medical education differentiated the development of the study of medical ethics in Britain from other countries. What were these distinguishing factors? Did the medical groups exert an influence on individual doctors and on medical education? What has been gained (or lost) by the inclusion of ethics in the medical curriculum?

The questionnaire

A draft questionnaire was devised and was submitted, firstly, to a pilot group of former student officers of the LMG, and, secondly, for approval by an Advisory Group, appointed by the Governing Body of the Institute, Professors Kenneth Boyd, Ranaan Gillon and Margaret Lloyd. The questionnaire was sent to as many former medical students who were named as ‘reps’ in the annual lecture lists with entries in the *Medical Directory* for 2004. Although there was a minority of reps from nursing and other allied disciplines, it proved impossible to trace them, since they were usually not identified by discipline but recorded only as ‘other’ in LMG lecture lists. Thus this study focuses exclusively on those whose medical training included exposure to LMG lectures, symposia, seminars and conferences between 1963 and 1989.

A further limitation was that, although it had been intended to send the questionnaire to those involved in the Scottish and Provincial medical groups, very little documentary evidence appeared to have survived. It should also be noted that the responses come from former students who had been actively involved in promoting the lectures and symposia in their own hospitals: those who only attended could obviously not be traced. An inspection of the Institute’s archive (prior to its being deposited with the Wellcome Library) failed to produce any lecture lists of the Scottish and Provincial medical groups previously held in the former LMG offices in London.²⁵⁵ Thus this aspect of the study is restricted to those doctors who were representatives of the LMG during their training in the then 12 London teaching hospitals and their associated medical schools.

The response

Of the 779 former student reps named in the LMG lecture lists, 483 were identified in the *Medical Directory 2004* and were sent the questionnaire during 2005; 217 replies were received (45 per cent). No reminders were sent as replies were anonymous unless signed and non-respondents could not be identified [Appendix 6].

²⁵⁵ The IME archive is held as SA/IME in Archives and Manuscripts, the Wellcome Library, London.

Most respondents (60 per cent) had been clinical students when they first attended a medical group lecture or symposium. While of these most (66 per cent) said they had been first attracted by the topics and the speakers.

Eighty-four per cent of respondents said they knew of no other source of teaching or learning about medical ethics, either in the curriculum or extra-curricular. There was:

A woeful lack of teaching and discussion of medical ethics in the curriculum.

I do not recall any other ethical teaching (other than, ‘When I hear the word ethics, I reach for my golf clubs’.)

The arrival of the LMG lecture list was *always* something to look forward to.

When asked whether they could recall any medical group topics or lecturers, 30 per cent pleaded amnesia after 30 or 40 years. Of those who responded, 94 could recall a particular lecturer’s name, of whom 31 (33 per cent) mentioned Cicely Saunders and/or her lecture on the ‘Nature and management of terminal pain’. Other names mentioned included Ivan Illich (named by 7 respondents); Anthony Clare (6); Jack Dominian (6); Gordon Dunstan (5); Anthony Bloom (4); Ian Kennedy (2); Wendy Savage (2); and Katharine Whitehorn (2).

When asked whether they had positive or negative views of the way the LMG was organized (with a student Representative Council and a senior Consultative Council), 89 per cent responded positively.

Reps were allowed to feel like grown-ups.

Positive memories of student views being respected and valued.

Ninty per cent approved of the way topics were identified by students, while 93 per cent approved of the way lecturers were suggested by the multidisciplinary Consultative Council.

Strengths and weaknesses

Asked to evaluate with hindsight the strength or weakness of the medical group method, replies included:

Main strength: the way it empowered students.

Extremely innovative.

It was pioneering: we need more ethical discussion in postgraduate education.

One of the most successful methods of encouraging medical students to think.

At the time the LMG was a unique group and the only way I had of engaging in ethics discussions as an undergraduate.

The ripples of influence that the LMG created may go much further than your survey suggests.

LMG was often ahead of public debate.

LMG was a ground-breaking initiative. I am only sorry not to see it continue for the students of today.

The programme was amazing.

LMG changed the London medical learning experience.

The best part of my very dull course.

Still enthusiastic about the LMG – 30 years later.

Asked whether the LMG was successful as a multidisciplinary forum, 81 per cent thought it successful (53 per cent very; 28 per cent quite, 19 per cent not).

Ninety-two per cent rated it successful as an introduction to medical ethics (76 per cent 'very'; 16 per cent 'quite'; 3 per cent 'not'; 5 per cent 'not sure').

Only 10 per cent thought that the LMG had a specific influence on their career, but 39 per cent thought it influenced their daily practice while 42 per cent thought it had no influence, with 11 per cent unsure. Eighty per cent claimed to be involved in medical ethics, while 17 per cent said they were not and 2 per cent were not sure.

The medical group method was thought to have had a positive influence on undergraduate medical education by over half (52 per cent) of respondents while most (62 per cent) were not sure whether its influence reached postgraduate medical education.

Although most were not clear whether it had influenced medical practice, some who were (39 per cent) were specific:

Exposure to ethical discussions on 'Death, dying and palliative care' has influenced my practice.

But only a quarter (26 per cent) thought it had influenced public debate.

Were there any lessons to be learned from the medical group method for today's teaching of medical ethics? Two-thirds (67 per cent) were convinced that there are:

It remains a valid approach.

So much of modern teaching is a series of bullet points

A refreshing change from didactic medical teaching.

It was the one part of learning about medicine that felt like being at university

A good method and worthy of continuance.

I hear medical students repeatedly complain how dry the curriculum is.

The current courses (in medical ethics) would benefit greatly from Symposia-type discussion.

Since I have qualified, I have seen the new 'compulsory' top-down teaching of ethics. My impression is that the new way is very didactic and directive.....A complete contrast to the discussional approach of the LMG. I much prefer the latter.

I think the current approach is very inferior to the LMG. Current students are able to tell me what they have heard (in lectures) is ethical. They do not seem to think an individual doctor should make a personal decision as to what is ethical. In that sense, I think we have gone backwards from the days when I attended the LMG (in 1977).

Opened my eyes to things that just didn't appear in the curriculum at all. – [A Dean]

I will always remember my first year at the medical school – having dinner with Robert Winston (then of IVF rather than TV fame) and being amazed the LMG could facilitate this.

A victim of its own success, since it encouraged ethics teaching in medical schools.

An idea whose time has gone?²⁵⁶

Whether or not this view was the considered opinion of the Conference of Metropolitan Deans, it was borne out neither by the Pond Report, which recommended the inclusion of ethics in the undergraduate curriculum alongside the medical groups, nor by former LMG student office-holders:

Something was lost when ethics became an official subject. The quality and status of its teachers is not as strong or as broad.

As an official subject it suffers from institutionalisation of the curriculum – including learning objectives and there is a tendency for approaches to be politically correct. The freedom, responsibility and spontaneity (topicality) is lost. As a vision of what needed to be done to enhance the education of clinicians, it stands as a landmark (to your) contribution to the enrichment of the NHS to the benefit of patients, which remains as topical and important today.

For a great many of us, participation in the LMG and the other medical groups was very influential in our way of thinking about medical practice. It was a very important influence on how I matured.²⁵⁷

On a personal level, I was very honoured and proud to help with the work of the LMG in its tenth year – something that remains on my CV to this day.²⁵⁸

I have come to believe that it was a much better way to foster interest than the present rather insipid fare that is doled out to medical students that I meet since the medical schools have taken on this role. The only weakness was that it reached only a minority but I think that was inevitable....If the medical groups or similar could be re-formed they would be a very welcome balance to the view that medicine is easy.²⁵⁹

If the only weakness of the medical group was that its extra-curricular and therefore voluntary nature ensured that it attracted only a small proportion

²⁵⁶ Attributed to Professor Peter Richards, Dean of St Mary's Hospital Medical School, and Professor of Medicine, St Mary's Hospital Medical School, 1979–95.

²⁵⁷ Patrick Coyle, Charing Cross Hospital Medical School, LMG Publicity Secretary, 1968/9.

²⁵⁸ Simon Walford, the London Hospital Medical College, LMG President, 1973/4.

²⁵⁹ John Bull, St Thomas's Hospital Medical School, LMG President, 1969/70.

of students, its strength was that its very existence pointed to a deficiency in medical education. Has the introduction of ethics in the form of moral philosophy as applied to medicine adequately explored the moral dilemmas of medical practice? Has the gain been greater than the loss? If not, can the gap left by the demise of the medical groups – discussion of issues identified by clinical students and not by medical teachers – be filled within the hierarchical milieu of medical education? Could the medical group method be adopted within the curriculum or was its very independence essential to its success? And, given that the respondents to the questionnaire were all actively involved in the medical group method of identifying and promoting the discussion of issues raised by the practice of medicine, has distance lent enchantment to the view?

The view of former students, that there is still a place for LMG-type symposia, alongside curriculum teaching, is supported by editorial comment on a paper by Michael Barr on ‘Clinical ethics teaching in Britain’.²⁶⁰

Barr explores a defining moment in the development of medical ethics teaching in Britain, the establishment of the London Medical Group and notes how British medical ethics, as defined by the Medical Groups’ topics of discussion, originally extended much more widely than has become usual in modern bioethics. This is indeed ironic; part of the attraction [sic] of the term bioethics has been the promise of moving beyond the preoccupation of ‘conventional medical ethics’ with the relationship of doctor and patient. Although some such shift of focus has clearly taken place, bioethics certainly does not reflect the diversity of ethical interests apparently shown by medical students three or four decades ago. [Along with] truth-telling, mental health, end of life issues or new reproductive technologies, also on the ethical agenda were issues such as marriage guidance, bisexuality, war, nuclear weapons, cannabis use, poverty, unemployment and the welfare state. Put in these terms, one of the tasks of contemporary bioethics is to recover some of its predecessors’ commitments to more broad-ranging, and indeed more political enquiry.²⁶¹

Sir Douglas Black, writing in 1988, could see a continuing need for a multidisciplinary element in the discussion of medico–moral questions:

²⁶⁰ Barr (2003): 73–4.

²⁶¹ Barr (2003): 74–8.

Although official bodies such as the General Medical Council now recommend the teaching of medical ethics as part of the formal medical course, this in no way removes the need for an organization which is independent of the particular interests of any single profession; whose considerations of ethics stems from a multidisciplinary base; and so can range widely over the ever-increasing number of ethical problems arising in the context of health care.²⁶²

Just imagine spending all those hours in medical school lecture theatres – and having absolutely nothing to show for it. – Professor Sir Stanley Peart discussing my attendance at LMG lectures and symposia.²⁶³

Acknowledgements

Nothing could have been achieved without the enthusiastic support of succeeding generations of students who acted as medical group representatives in their own teaching hospitals and, in particular, without the commitment of successive LMG Presidents who also acted as conveners of the annual conferences.

I owe a huge debt of gratitude to those clinicians and others who so readily gave their time to advise and support the development of the study of medical ethics: especially to Lord Amulree, under whose chairmanship Governing Body meetings never exceeded 90 minutes; The Revd Professor G R Dunstan, whose vast experience of multidisciplinary collaboration influenced both the choice of non-medical participants for symposia and the composition of research working parties, several of which he chaired; and Dr R D Catterall who, as Chairman of the Consultative Council, helped develop the LMG lecture list by insisting that, if cutting edge clinicians could not be secured, then discussion of a particular issue should be deferred to the following year.

I am most grateful to Prebendary Eric Tinker, Senior Chaplain to the University of London, for his early and continuing support and am particularly grateful to the then Bishop of London, Dr Robert Stopford, who gave me freedom to pursue this work, by creating a ‘modern sinecure’ in which he appointed me to be a chaplain to the University while failing to nominate a college.

Over the years, I had the sterling support of a series of secretaries, without whose dedication and tolerance, no lecture list would ever have materialized: in

²⁶² Institute of Medical Ethics (1988): 5.

²⁶³ I resigned as Director of the IME on appointment as Dean of Rochester in November 1989.

particular Sheila Finnis, an experienced university secretary, who brought new skills to our office and Helen Horton, who joined us post-retirement, bringing a vast experience of dealing with VIPs.

This report has greatly benefited from the comments of the Advisory Group appointed by the Institute of Medical Ethics: Professor Raanan Gillon, the longest serving Editor of the *JME* and promoter of an annual course in Medical Ethics at Imperial College, London; Professor Margaret Lloyd, Professor of Primary Care and Medical Education at UCL and one of the first LMG reps in 1963; and last but not least, Professor Kenneth Boyd, Professor of Medical Ethics in the University of Edinburgh, without whom the medical group method might never have been identified and translated into a programme of research and publication. This report describes a collaborative exercise and encapsulates my sincere thanks to all those, named and un-named, whose support made it possible. All omissions and errors are, of course, my own. *Mea culpa; mea maxima culpa.*

Edward Shotter

Amulree Fellow, Institute of Medical Ethics

16 September 2006

Post Script

Professor Raanan Gillon, Chairman, Institute of Medical Ethics, 2006

One omission that must surely be remedied is the paucity of reference in his report to comments on Ted Shotter's own crucial role in the development and running of the medical groups. As a member of the advisory group to this project I had the pleasure of reading the questionnaire responses and Ted has been far too modest in his report in his culling of references to himself. Respondents write in glowing terms of his inspirational effect on them, of his battles to raise funding, of his 'huge contribution', of his even-handed management of the organization, his keenness to involve multidisciplinary discussion, especially between doctors and nurses, medical students and nursing students, of his creation of 'a slightly intellectual alternative to normal medical studies', and of 'a refreshing change from didactic medical teaching'. He is repeatedly thanked for his positive influence on respondents' medical school experiences and subsequent careers. There are references to his drive and charisma, his skill in managing 'the outfit', in recognizing and enticing good speakers, his 'impartial and even-handed representation of all parties in debates – if it had been a "Christian" mouthpiece only it would have lost much of its impact', and his 'openness to others' views'. His qualities as an interesting and amiable host are noted, both at his London flat and at the post-symposia dinners at which both speakers and student reps recall pleasurable meals and stimulating discussions. As one respondent put it, Ted 'was rather unique in doing what he did with medical ethics'. The responses to the questionnaire make clear that it was Ted's drive and enthusiasm and managerial efficiency, combined with his friendly outgoing 'clubability' that created that most remarkable medical ethics organism, the London Medical Group, and its close relatives in all the other British medical schools.

Appendix 2

Some reflections on the London Medical Group²⁶⁴

Letter from Dame Cicely Saunders to
the Very Revd Edward Shotter, 17 November 2004

I cannot date my first contact with the ideas that developed into the Medical Groups but I remember a discussion with the original researcher and our agreement that the initiative, planning and development had to come from the medical students and recent graduates themselves.

My first lecture in the 1963/4 list was given at the London Hospital and was entitled 'Pain'. This had developed by 1972 to 'The Nature and Management of Terminal Pain'.

It became an annual event, until I drew stumps after 25 years.

These lectures were always full, often with standing room only and my talk mixed stories and statistics with slides I had taken of my patients to illustrate the bridge between science and our common humanity. Ted Shotter tells me that the content moved on over time, although the basic message remained the same. This will hopefully be illustrated by a collection of some of my papers of the past 40 years, to be published next year. The questions from the audience were always stimulating and had major input into the subject and its development.

My recollections include annual discussions with the medical school representatives and their repeated request for the topic illustrates how the students continued to demand a look at the humanistic side of medical education. That the particular subject of the end of life care is a challenging way of approaching this is illustrated by the number of Medical Groups in other cities that chose it as their inaugural lecture. Bristol, Aberdeen, Liverpool and Manchester come to mind but there were others. This had, I believe, an impact on the fact that palliative medicine became a General Medicine sub-specialty in 1987. It was a 'bottom up' movement.

My other memories are of the cheerful and challenging dinners (with the local reps), which were very welcome honoraria, as the restaurants were always well-chosen. Ted Shotter himself always managed to enable the committee to take

²⁶⁴ Selected from encomiums received by the author.

charge yet gave essential back-up, as he did with the whole exercise. I recall with great pleasure Ted's appearance in mufti at the first evening of the excellent annual conferences'. 'I thought he was a riverboat gambler,' said Professor Balfour Mount from Montreal following one such event at which he was a speaker.

Summing up at conferences fell to my lot at times and I will never forget the impact made by Professor Patrick Wall as he gave his talk on 'Pain', presented as only he could. These conferences were deservedly popular and imaginative.

A number of past reps have crossed my path over the years. The Groups made a considerable impact on the development of medical education and, I believe, on the practice of medicine generally. I wish that the values that were embodied could be as effectively presented as in those early days, which I remember with such pleasure. It was a stimulating contact from which I not only profited, but also very much enjoyed.

Letter from Dr Duncan Catterall CBE to
the Prebendary Edward Shotter, 19 October 1988

I should like to say how much I have enjoyed my association with you [Ted Shotter] over the past few years and how much I have come to admire all that you have done for medical students and others during that time. I believe that your concept of the LMG and the skilful way in which you expanded it and translated it into the superb organization that has evolved, deserves much greater recognition and appreciation than it has yet received.

I should like you to know that I have regarded it as a great privilege to work with you and to watch how you conducted meetings and conferences with great humility and modesty.

Letter to LMG donors from Mr David Lister, 8 September 1975

You will remember that in the autumn of 1967, I wrote to you seeking a contribution for my friend Edward Shotter for his work with the London Medical Group, then a young and tentative body set up among medical students in London to provide for them a forum for the study and discussion of medical ethics, a subject that was omitted as a specific subject of study from the curriculum of the medical schools.

I am not a member of the medical profession; I am a lawyer, but it then appeared to me that in this subject of medical ethics was one of the crucial topics of intellectual humanitarian debate – and anguish – not only for the present, but many years to come. Here was an area of discussion which transcended the technical boundaries of medical science but was of concern to all humanity: to philosophers and lawyers, to sociologists and theologians, to the religious of all creeds and to agnostics and atheists alike. Above all, I saw in this embryonic movement the realization of that care and concern for individuals and ‘cases’ as living people which must be fostered in all professions and callings if civilization is to continue to have any living meaning. As a consequence of these convictions, and out of a strong regard for Edward Shotter, I did something which looking back now never ceases to astonish me, for it was quite outside my normal retiring nature: I launched a personal appeal for funds from all manner of people I knew to have been associated with Edward Shotter – his personal friends and relatives, school friends and schoolmasters, university dons, diocesan bishops, a secret service agent, people living as far away as the United States and Thailand. And I thought nothing of sending polite reminders, if I did not receive a reply. The response was remarkable: I quickly collected £700 which in due course I paid to Edward with a simple list of donors.

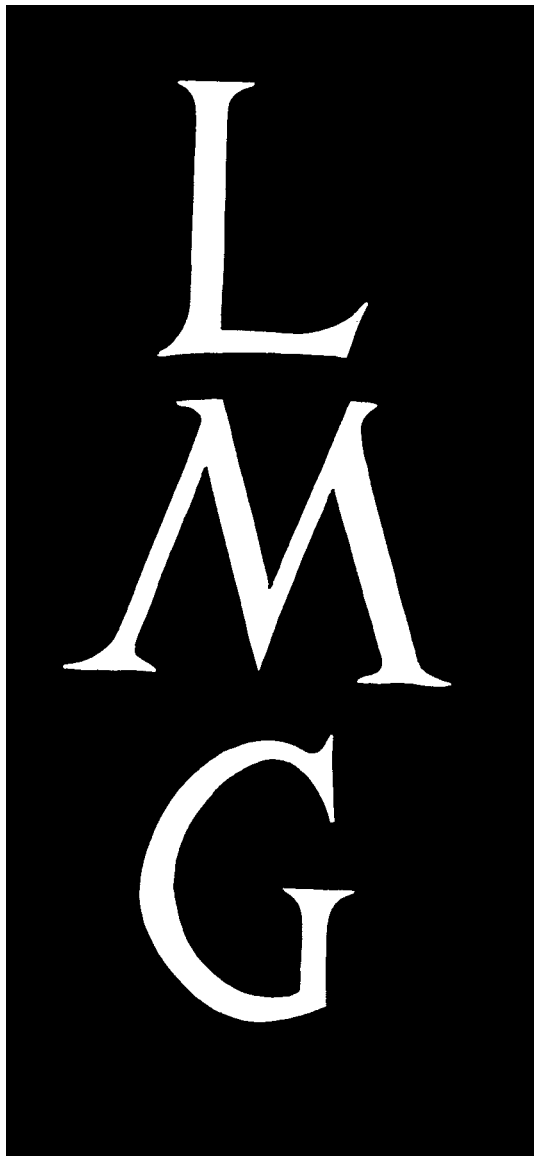
At a time when his spirits were flagging, this was just the tonic which was needed to encourage him with his work. The sum of £700 was exactly the sum needed to save the London Medical Group from financial collapse.... While this view may not be shared by all who joined me, I have come to see my action as providential. Be this as it may, the London Medical Group survived, new sources of income were found; the lectures and symposia and conferences were extended and gradually recognition was accorded to its work by the London medical schools.

In 1967 the great debate on medical ethics was hardly beginning: there had been no heart transplants; no fertilization *in vitro*; the euthanasia debate had

not become fashionable; there was little talk of iatrogenic (doctor-induced) illness. Now medical ethics has become a topic of daily debate, not only among the medical profession but also in newspapers and magazines and above all on television. The need for competent bodies like the London Medical Group to give student doctors a realistic introduction to the heart-rending problems and decisions they will face in practice is no longer desirable: it is axiomatic.

Appendix 3

LMG lecture list, 1981/2



1981/82
London Medical Group lecture list
REVISED JANUARY 1982



Phone
01-387 2129

Telegrams and Cables:
MEDETHIC LONDON WC1



LONDON MEDICAL GROUP

OFFICERS 1981-82

President:
Alan Schamroth, BSc (Middlesex)
Past President:
Patrick Magee, MSc MB BS
Secretary:
Ian Leonard, BSc (Guy's)
Junior Treasurer:
Pamm Wiggan, SRN (Guy's)
Publicity Officer:
Gerald Smith, BSc (Bart's)

LMG is an independent, non-partisan student group for the study of issues raised by the practice of medicine which concern other disciplines.

LMG has no members: lectures and symposia are addressed to medical, nursing and other students in the twelve London teaching hospitals and are open to all students and others professionally interested.

LMG is represented in the hospitals by a team of medical, nursing and other students or those recently qualified and who have volunteered to serve on the Representative Council.

LMG is multidisciplinary: topics for lectures and symposia result from a student critique of medical practice and education. The Consultative Council helps identify lecturers and to this end includes representatives of other disciplines such as law, moral philosophy, moral theology and the social sciences as well as the medical specialities.

LMG lectures and symposia are free: the LMG is financed by voluntary donations and is an educational charity. There is a nominal registration fee for study seminars and a reduced fee for students at the Annual Conference; there is no charge for attendance at lectures and symposia.

ADMINISTRATION

The LMG and SSME offices are open on weekdays from 9 am to 5 pm Room 68, Fourth Floor, Tavistock House North, Tavistock Square, London WC1H 9LG. Telephone 01-387 2129/8132.

The Director or a secretary is available at these times throughout the academic year to give information or advice, and for the collection of lecture lists, posters, etc.

Director of Studies	Edward Shotter, BA
Research Fellow*	Richard Nicholson, MA BM BCh DCH
Assistant Directors*	Brendan Callaghan, SJ MA MPhil MTh Raanan Gillon, BA (Phil) MB BS MRCP Dorian Haskard, MA MRCP
Personal Assistant	Susan French, BA
Assistant Secretary	Ingrid Briggs, MA
Secretaries*	Maureen Bannatyne Sheila Finnis Helen Horton
Telephones	01-387 2129 (LMG) 01-387 8132 (SSME)

*Part-time staff.

DIARY OF MEETINGS 1981-82

Representative Council
6-7.30 pm Wednesdays 30th September 1981, 6th January 1982.

Executive
6-7.30 pm Mondays 14th September (Publicity), 9th November (1982/83 Lecture List), 7th December 1981 (Nominations), 8th February 1982 (Pre-Conference).

Consultative Council
6 for 6.30 pm Wednesdays 3rd February and 21st April 1982.

Governing Body
5-6.30 pm Wednesday 7th October 1981, 10th March, 9th June 1982.

LONDON MEDICAL GROUP OPEN LECTURES AND SYMPOSIA FOR 1981-82

All symposia and lectures will end after one hour and 15 minutes unless otherwise indicated

OCTOBER – DECEMBER

ILLUSTRATED SYMPOSIUM: BRAIN DEATH: Are the medical criteria acceptable to the public?

6 pm Tuesday 6th October 1981 Charing Cross Hospital, Fulham
Chairman: Professor Norman Morris, MD FRCOG, Professor of Obstetrics and Gynaecology, Charing Cross Hospital Medical School
Bryan Jennett, MD FRCS, Dean of Medicine and Professor of Neurosurgery, University of Glasgow
Bruce MacGillivray, BSc FRCP, Dean, Royal Free Hospital School of Medicine
Ian Kennedy, LL.M., Reader in the Faculty of Laws, King's College London

SYMPOSIUM: SURVIVAL OF THE WEAKEST: The morality of inaction in the care of the malformed infant

5 45 pm Thursday 8th October 1981 Guy's Hospital
Chairman: B. G. R. Neville, FRCP, Consultant Paediatric Neurologist, Guy's Hospital
Professor John Lorber, MD FRCP, Professor of Paediatrics, Sheffield University
Professor G. R. Dunstan, MA DD FSA, Professor of Moral and Social Theology, King's College London
Nuala Scarisbrick, Honorary National Administrator of LIFE

ILLUSTRATED SYMPOSIUM: LIFE AT ALL COSTS? Transplants and scarce resources

5 45 pm Tuesday 13th October 1981 King's College Hospital
Chairman: L. T. Cotton, MCh FRCS, Dean, King's College Hospital Medical School
M. Bewick, MA MB BChir FRCS, Consultant Surgeon, Guy's Hospital Medical School
J. A. Muir Gray, MB ChB DPH, Community Physician, Radcliffe Infirmary, Oxford

ILLUSTRATED SYMPOSIUM: MARIJUANA: Its medical effects and social implications

5 45 pm Thursday 15th October 1981 The London Hospital
Chairman: S. N. Wolkind, MD FRCPsych, Senior Lecturer in Clinical Psychiatry, The London Hospital Medical College
Philip Boyd, MB BS MRCPsych, Consultant Psychiatrist, The Middlesex Hospital
John M. Littleton, BSc PhD MB BS, Reader in Pharmacology, King's College London
M. S. Rose, MB BS PhD MRCPsych, Senior Lecturer in Haematology, St George's Hospital Medical School

ILLUSTRATED SYMPOSIUM: ABANDON HOPE? The consequences of euthanasia legislation

5 45 pm Tuesday 20th October 1981 Middlesex Hospital Medical School
Chairman: John Hinton, MD FRCP FRCPsych, Professor of Psychiatry, The Middlesex Hospital Medical School
Colin Brewer, MB MRCS MRCPsych, Consultant Psychiatrist, Hillingdon AHA
T. S. West, OBE MB BS, Deputy Medical Director, St Christopher's Hospice
John Mathew, QC

SYMPOSIUM: IN TOUCH: The effects of physical contact on the therapeutic relationship

5 45 pm Thursday 22nd October 1981 Royal Free Hospital, Hampstead
Chairman: S. W. Clarke, MD FRCP, Consultant Physician, Royal Free Hospital School of Medicine
Graham Knight-Webb, MB BS MRCP FRCP(C), Consultant Psychiatrist, Cleeve House Adolescent Unit, Gloucester
Lesley Southgate, MSc MB ChB MRCCP, Lecturer in Primary Care, St Bartholomew's Hospital Medical College
Clive Lindley-Jones, DO BEd MSO, Osteopath

FILM AND DISCUSSION: KILL OR CURE: The role of the doctor in nuclear war

A showing of 'The War Game' followed by discussion
5 45-7 30 pm Tuesday 27th October 1981 St Bartholomew's Hospital
Chairman: Professor F. J. Lawther, CBE DSc FRCP, Professor of Environmental Medicine, St Bartholomew's Hospital Medical College
Andrew Haines, MB BS MRCP MRCCP, MRC Epidemiology Unit, Northwick Park Hospital
Sir Arthur Hockaday, KCB CMG, Second Permanent Under Secretary of State, Ministry of Defence
B. A. Paskins, BA PhD, Lecturer in the Department of War Studies, King's College London

SYMPOSIUM: SEXUAL ABUSE OF CHILDREN: Fleeting trauma or lasting disaster?

6 pm Thursday 29th October 1981 St George's Hospital, Tooting
Chairman: Professor A. H. Crisp, MD FRCP FRCPsych DSc
Amnon Bentovim, MB BS FRCPsych DPM, Consultant Psychiatrist, Great Ormond Street Hospital; Department of Children and Parents, Tavistock Clinic
Carolyn Okell Jones, BSc, Senior Social Worker, Student Unit Supervisor Child Guidance Training Centre

SYMPOSIUM: IS BIRTH TOO IMPORTANT TO BE LEFT TO MOTHERS?

5 45 pm Tuesday 3rd November, 1981 St Mary's Hospital
Chairman: D. B. Paintin, FRCOG, Senior Lecturer in Obstetrics and Gynaecology, St Mary's Hospital Medical School
S. J. Steele, FRCS FRCOG, Director, Academic Department of Obstetrics and Gynaecology, Middlesex Hospital
Caroline Flint, SRN SCM, Antenatal Clinic Sister
Mrs Patricia Dewar, a mother

ILLUSTRATED SYMPOSIUM: THE MEDICAL AND MORAL CONSEQUENCES OF UNEMPLOYMENT

5 45 pm Thursday 5th November 1981 St Thomas's Hospital
Chairman: Professor W. W. Holland, BSc MD FRCP FFCM
J. Tudor Hart, MB DCH FRCP, General Practitioner
Rachel Jenkins, MA MB BChir MRCPsych, Clinical Lecturer, Institute of Psychiatry
The Revd J. R. Atherton, MA PhD, Director, William Temple Foundation, Manchester

ILLUSTRATED SYMPOSIUM: NURSE, I WANT MY MUMMY: The needs of children in hospital

5 45 pm Tuesday 10th November 1981 University College Hospital
Chairman: Professor Leonard Strang, MD FRCP
Stuart Carne, OBE MB BS FRCP DCH, Senior Tutor in General Practice, Royal Postgraduate Medical School
Priscilla Alderson, Chairman of the National Association for the Welfare of Children in Hospital
Margaret Atkin, Principal Social Worker, Social Service Department, Great Ormond Street Hospital

ILLUSTRATED SYMPOSIUM: THE EMOTIONAL NEEDS OF THE DISABLED

6 15 pm Thursday 12th November 1981 Westminster Hospital
Chairman: Sir Richard Bayliss, KCVO MD FRCP, Consultant Physician, The Westminster Hospital
The Rt Hon Baroness Masham of Ilton, Countess of Swinton
Elizabeth C. Rogers, RGN SCM ONC, Nursing Officer, National Spinal Injuries Centre, Stoke Mandeville
Michael A. Rogers, Author of *Paraplegia*

SYMPOSIUM: BEHAVIOUR MODIFICATION: Brain washing or good psychiatry?

6 pm Tuesday 17th November 1981 Charing Cross Hospital, Fulham
Chairman: J. E. H. Pendower, MB BS FRCS, Consultant Surgeon and Vice-Dean, Charing Cross Hospital
J. P. Cobb, BA MRCP MRCPsych, Consultant and Senior Lecturer in Psychiatry, St George's Hospital
S. P. R. Rose, BA PhD FIBiol, Professor of Biology, The Open University
Paul Sieghart, Chairman, Executive Committee, *Justice*

SYMPOSIUM: DIAGNOSTICIAN, PRACTITIONER AND THERAPIST: Is the new nurse a threat to the medical profession?

5 45 pm Thursday 19th November 1981 Guy's Hospital
Chairman: Ann Moss, SRN RMN, Senior Nursing Officer (Psychiatry), Guy's Hospital
H. John Anderson, MA MB BChir FRCP, Senior Physician, St Thomas's Hospital Medical School
Professor J. P. Watson, MD FRCP FRCPsych, Professor of Psychiatry, Guy's Hospital
June Clark, Research Fellow in Nursing and Community Health Studies, Southbank Polytechnic

SYMPOSIUM: BEREAVEMENT: A treatable condition?

5 45 pm Tuesday 24th November 1981 King's College Hospital
Chairman: Professor J. Anderson, MA MD BSc FRCP
David Morris, FRCP DCH, Consultant Paediatrician, Brook Hospital; Chairman National Stillbirth Study Group
Colin M. Parkes, MD FRCPsych DPM, Senior Lecturer in Psychiatry, The London Hospital
The Revd Peter Speck, MA BSc, Chaplain, Royal Free

SYMPOSIUM: THE RISE OF THE GERONTOCRACY: The impact of pensioner power on society

5.45 pm Thursday 26th November 1981 The London Hospital
 Chairman: Professor R. D. Cohen, MA MD FRCP, Professor of Metabolic Medicine, The London Hospital
 John Agate, CBE MA MD FRCP, Consultant in Geriatrics, Ipswich Hospital
 Anthony Mann, MPhil MA MB MRCP MRCPsych, Senior Lecturer in Psychiatry, The Royal Free Hospital
 David Hobman, Director, Age Concern

SYMPOSIUM: THE TRUTH, THE WHOLE TRUTH AND NOTHING BUT EVASION: The art of communicating with the patient

5.45 pm Tuesday 1st December 1981 The Middlesex Hospital Medical School
 Chairman: Professor M. W. Adler, MD MRCP MFCM, Professor of Genito-Urinary Medicine, Middlesex Hospital
 C. M. Una Maclean, MD PhD DPH, Reader and Head of the Department of Community Medicine, Edinburgh University
 Professor Eric Wilkes, OBE MA FRCP FRCPsych
 Obst RCOG, Professor of Community Care and General Practice, University of Sheffield
 Susan Gowers, SRN RCNT, Senior Nursing Officer, Trent Regional Health Authority

SYMPOSIUM: CHILDREN IN CARE: The risks involved

5.45 pm Thursday 3rd December 1981 Royal Free Hospital, Hampstead
 Chairman: Paul T. d'Orban, MB ChB FRCPsych DPM, Consultant Forensic Psychiatrist, The Royal Free Hospital
 Brendan MacCarthy, MD MSc FRCPsych, Consultant Child Psychiatrist, Child Guidance Training Centre
 Pauline Crabbe, OBE JP, Vice Chairman, Brook Advisory Centres
 Rose Robertson, Director and Senior Counsellor for Parents' Enquiry (for the parents of homosexual children)

ILLUSTRATED LECTURE: THE NATURE AND MANAGEMENT OF TERMINAL PAIN

5.45 pm Tuesday 8th December 1981 St Bartholomew's Hospital
 Dame Cicely Saunders, DBE MA MD FRCP, Medical Director, St Christopher's Hospice

SYMPOSIUM: THE THREAT OF PRIVATE MEDICINE: Inequality or excellence?

6 pm Thursday 10th December 1981 St George's Hospital, Tooting
 Chairman: Professor Peter Millard, MB FRCP, Professor of Geriatric Medicine, St George's Hospital Medical School
 Stanley Balfour-Lynn, MB BS MRCS LRCP, Chief Executive Officer, American Medical (Europe) Ltd
 Nicky Hart, BSc PhD, Research Fellow to the *Black Committee* on Inequalities in Health

JANUARY — MARCH

ILLUSTRATED SYMPOSIUM: PORNOGRAPHY AND THE EXPLOITATION OF FANTASY: What can legislation achieve?

5.45 pm Tuesday 5th January 1982 St Mary's Hospital
 Chairman: Professor Peter Richards, MA MD PhD FRCP, Dean, St Mary's Hospital Medical School
 Professor Sydney Selwyn, MD ChB BSc FRCPsych FIBiol DHMSA, Professor of Medical Microbiology, Westminster Medical School
 Maurice Yaffé, PhD, Senior Clinical Psychologist, Guy's Hospital
 David Tudor Price, one of the Senior Treasury Counsel at the Central Criminal Court

ILLUSTRATED SYMPOSIUM: DOES ANTENATAL DIAGNOSIS PROVIDE A MORAL GROUND FOR ABORTION?

5.45 pm Thursday 7th January 1982 St Thomas's Hospital
 Chairman: R. W. Taylor, MD FRCOG, Professor of Obstetrics and Gynaecology, St Thomas's Hospital
 Eva Alberman, MA MD MRCP, Professor of Clinical Epidemiology, The London Hospital Medical College
 Mary Seller, BSc PhD, Senior Lecturer in Experimental Biology, Paediatric Research Unit, Guy's Hospital
 Gerard J. Hughes, SJ, Head of the Department of Philosophy, Heythrop College

ILLUSTRATED SYMPOSIUM: CAN MEDICAL ETHICS BE TAUGHT?

5.45 pm Tuesday 12th January 1982 University College Hospital
 Chairman: Gerald Stern, MD FRCP, Consultant Neurologist, University College Hospital
 Professor Sir Cyril Clarke, KBE, Director of the Medical Services Study Group, Royal College of Physicians
 R. B. Welbourn, MA MD FRCS, Professor of Surgical Endocrinology, Royal Postgraduate Medical School
 Michael Lockwood, MA DPhil, Lecturer in Philosophy, University College, Oxford

ILLUSTRATED SYMPOSIUM: CIGARETTE SMOKING: Could the benefits outweigh the risks?

6.15 pm Thursday 14th January 1982 Westminster Hospital
 Chairman: R. A. M. Forrest, BA, Secretary, Westminster Medical School
 Mike Daube, BA, Senior Lecturer in Health Education, Dept. of Community Medicine, Edinburgh University
 Professor H. J. Eysenck, PhD DSc, Director of the Psychological Research Laboratories, Institute of Psychiatry

LECTURE: PREPARATION FOR DEATH

6 pm Tuesday 19th January 1982 Charing Cross Hospital, Fulham
 Metropolitan Anthony of Surozh, MD DD

SYMPOSIUM: THE PLACE OF PSYCHIATRY IN MEDICINE

5.45 pm Thursday 21st January 1982 Guy's Hospital
 Chairman: Professor Ian McColl, MS FRCS, Professor of Surgery, Guy's Hospital
 Professor W. S. Peart, FRS MD FRCP, Director of Medical Unit, St Mary's Hospital
 Sir Desmond Pond, MD FRCP FBPSS PRCPsych, Professor of Psychiatry, The London Hospital Medical College

***SYMPOSIUM: BEYOND THE MEDICALISATION OF HOMOSEXUALITY**

5.45 pm Tuesday 26th January 1982 King's College Hospital
 Chairman: Philip Hugh-Jones, MA MD FRCP, Director of Chest Unit, King's College Hospital
 Sidney Crown, PhD FRCP FRCPsych, Consultant Psychiatrist, The London Hospital
 Stephen Frank, MRCP MRCPsych DPM, Consultant Psychiatrist, Westminster Hospital
 Ray Lightbown, BSc BPhil ABPS, Area Clinical Psychologist, Cherry Knowle Hospital, Sunderland

***SYMPOSIUM: STRIVING OFFICIOUSLY: Could the NHS recover without further threat?**

5.45 pm Thursday 28th January 1982 The London Hospital
 Chairman: B. T. Colvin, MA MB BChir MRCP MRCPath, Senior Lecturer in Haematology, The London Hospital
 J. E. O. Dunwoody, MB BS MRCS LRCP, Chairman: Kensington, Chelsea and Westminster AHA (T)
 Geoffrey Finsberg, MBE JP MP, Parliamentary Under Secretary of State for Health and Personal Services

***FILM AND DISCUSSION: BIRTH WITH R. D. LAING**

5.45 pm-7.15 pm Tuesday 2nd February 1982 Middlesex Hospital Medical School
 Chairman: Sir Douglas Ranger, FRCS, Dean, Middlesex Hospital Medical School
 Geoffrey Chamberlain, MD FRCS FRCOG, Consultant Obstetrician and Gynaecologist, Queen Charlotte's
 Martin Richards, MA PhD, Lecturer in Experimental Psychology, University of Cambridge
 Ann Oakley, PhD, National Perinatal Epidemiology Unit, Radcliffe Infirmary, Oxford

LECTURE: MADNESS AND GENIUS — Is there an association?

5.45 pm Thursday 4th February 1982, Royal Free Hospital Hempstead
 Professor Sir Martin Roth, MD FRCP FRCPsych DPM
 Professor of Psychiatry, Addenbrooke's Hospital, Cambridge

SYMPOSIUM: THE MENTALLY HANDICAPPED: On the periphery of life and medicine?

5.45 pm Tuesday 23rd February 1982 St Bartholomew's Hospital
 Chairman: Professor G. M. Besser, MD DSc FRCP, Professor of Endocrinology, St Bartholomew's Hospital
 Joan Bicknell, MD FRCP, Professor of the Psychiatry of Mental Handicap, St George's Hospital Medical School
 Brian Riv, CBE, Secretary-General, National Society for Mentally Handicapped Children and Adults

***ILLUSTRATED SYMPOSIUM: DEPRESSION: Chemical imbalance or social response?**

6 pm Thursday 25th February 1982 St George's Hospital, Tooting
 Chairman: Professor E. S. Paykel, MD DPM FRCP FRCPsych, Professor of Psychiatry, St George's Hospital
 Professor G. W. Brown BA PhD, Professor of Sociology, Bedford College
 Professor F. A. Jenner, PhD FRCPsych, Professor of Psychiatry, University of Sheffield
 Professor D. Russell Davis, MD, Emeritus Professor of Mental Health, University of Bristol

a student group for the study of issues raised by the practice of medicine

Society for the Study of Medical Ethics

President:

The Rt Hon Lord Amulree, KBE MD FRCP

The Society for the Study of Medical Ethics was founded in 1972 by junior doctors previously associated with the London Medical Group. It aims to encourage a high academic standard for this developing subject and to influence both professional and public discussion by publishing the *Journal of Medical Ethics* and promoting medical groups.

The Society is associated with medical groups established in

London (1963)	Manchester (1975)
Edinburgh (1967)	Cardiff (1976)
Newcastle (1967)	Aberdeen (1977)
Sheffield (1972)	Southampton (1977)
Glasgow (1973)	Cambridge (1979)
Birmingham (1975)	Dundee (1979)
Bristol (1975)	Oxford (1979)
Liverpool (1975)	Leicester (1980)

GOVERNING BODY

The members of the Governing Body are representative of the various activities of the Society, namely the *Medical Groups*, the *Journal of Medical Ethics* and the *Multidisciplinary Studies in Medical Ethics*. The Society is a Company Limited by Guarantee and is registered as a charity.

The Rt Hon Lord Amulree, KBE MD FRCP, *Chairman*
 Professor R. B. Welbourn, MA MD FRCS, *Vice-Chairman*
 Margaret Auld, SRN SCM MTD MPhil NAdminCert

R. D. Catterall, FRCP
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 Pamm Wiggan, SRN (Guy's) (*ex officio*)

Secretary to the Governing Body:

Prebendary E. F. Shotton, BA, *Director of Studies*

ETHICS OF RESEARCH ON CHILDREN

The Society has established a multidisciplinary working party to study the ethics of clinical research investigations on children. Further information from the Director of Studies.

JOURNAL OF MEDICAL ETHICS

An international multidisciplinary quarterly published by the Society for the Study of Medical Ethics. The Journal promotes the study of contemporary medico-moral problems.

Subscription rate for one year (4 issues) is £19.00 for United Kingdom and Irish Republic, US \$48 Overseas, to: Subscription Manager, Journal of Medical Ethics, Tavistock House East, Tavistock Square, London WC1H 9JR

LIBRARY FACILITIES IN MEDICAL ETHICS

A common catalogue in medical ethics has been set up as a result of discussions between the librarians of the British Medical Association, King's College, London, and Heythrop College, London and the directors of the King's College Centre for Law, Medicine and Ethics, the Linacre Centre for the Study of the Ethics of Health Care and the Society for the Study of Medical Ethics. Further enquiries from the Director of Studies.

LMG REPRESENTATIVES

The London Medical Group is represented in the twelve London teaching hospitals by a multidisciplinary team of medical, nursing and other students, who constitute the *Representative Council*. Members of the Executive are indicated by two asterisks their alternates by one. Nurses, social workers students and members of allied professions are in *italics*. All others are medical students.

Charing Cross Hospital Miguel Nadal, Margaret Attwood*, Harriet Collins, David Meades**, Angus Kennedy, Nicholas Driver, Michael Katesmark, Ruth Palmer, Alison Wyrley-Birch

Guy's Hospital Lawrence Maule, Ian Leonard**, David Khoo, Julia Beck, Pamm Wiggan**, Andrew Williams*, Sue Reeve, *Jane Canterbury*

King's College Hospital Punam Mangtani, Fiona Weir, John Birkett, *Jane Evans*, *Christine Drew*, *Helen Wyke*, Katherine Kelly, Sue Mills**, Elizabeth Skiba*. Lanil de Silva, Michael Hird, Susan Wong, *Debbie Field*

The London Hospital Clare Batten, Tim Gerrard, Mike Tomson, Richard Festenstein, Diana Jellinek, Bridget Wagner, Sandra Evans, Peter Powell**, Carol Davis*, *Janine Toledo*, James Monro

The Middlesex Hospital Alan Schamroth**, Annie Bartlett*, Pat Lawton, Simon Dein, Timothy Robinson, Simon Wragg, Mark Davies, Amanda De Glanville, *Stephanie Lam*, *Kim Forecast*, *Alison Porter*, *Clio Nathaniels*, Jeremy Jacobs, *Anne Kroeber*

Royal Free Hospital Robert Walters, David Campbell**, *Angela Hoskins*, *Stella Smith*, Edwin Wood*, Tarulata Patel, *Carol Bennett*

St Bartholomew's Hospital Nigel Gibbons, Chris Lavy, Grania O'Mahony, Gerald Smith**, Sally Meecham Jones, Moira Whyte*, Jon Ireland, Lucinda Huskisson, Faith Gardner, Paul Carter, Julie McGowan, Andrew Stevens, *Sue Canty*

St George's Hospital *Peter Crowther***, Steven Pearce-Danker, Michael Eckstein*, Peter Brueck, Martin Hughes, Nicos Spyrou, Constantinos Missou

St Mary's Hospital Sue Beath**, David James, Mark Emberton*, Derek Rodrigues, Christine Bassindale, Pamela Harper, *Ros Jones*, Judy Bennett, John Uden, Nick Morris, Duncan Curr, Jane Wilkinson, Tejina Mangat, *Ron Gore*

St Thomas's Hospital *Rebecca Jackson*, Julian Skoyles, Heather Scopes, Andrew McMillan, Martin Walker, *Claire Prowse*, *Lorna Forse*, Nicola Griffiths**, Damian Eustace, *Carly Donald*, *Brynnan Massey*

University College Hospital Paul McKenna, Rosemary Nyholm, Emma Firman*, Tim Macmorland**, Richard Withers, Mike Fried, Beverley Sweeten-Smith, Anna Melnyk

Westminster Hospital Caroline Wilson**, Christopher Lyons*, *Karen Daly*, Stephen Tucker*, Michael Leeper, Fiona MacKellar, *Sarah Aldridge*

CONSULTATIVE COUNCIL 1981/82

The Consultative Council is a multidisciplinary advisory group which exists to ensure a high academic standard for the subjects suggested by the student Representative Council

Chairman: R. D. Catterall, FRCP, Consultant in Genito-Urinary Medicine, *Middlesex*; David Armstrong, MB BS MSc MRCS LRCP PhD, Senior Lecturer in Sociology, *Guy's*; Margaret Atkin, Principal Social Worker, *Great Ormond Street*; Christine Brown, SRN RSCN RNT, District Nursing Officer, *KCH*; Martin Brunton, MD MSc MRCP DCH, Senior Lecturer in Paediatrics, *Westminster*; William R. Cattell, MD FRCP FRCPE, Consultant Nephrologist, *St Bartholomew's*; Anthony Clare, MB MPHil MRCPsych, Senior Lecturer, *Institute of Psychiatry*; Professor A. H. Crisp, MD FRCP FRCPsych DSc, Professor of Psychiatry, *St George's*; Professor H. de Wardener, MBE MD FRCP, Professor of Medicine, *Charing Cross*; Peter Draper, MB BChir MFCM, Department of Community Medicine, *Guy's*; Professor The Revd Canon G. R. Dunstan, MA DD FSA, Professor of Moral and Social Theology, *King's College London*; Harold Edwards, FRCP, *formerly Dean of St Mary's*; Quentin Edwards, MA QC, *Barrister at Law, London*; Jonathan Glover, MA DPhil, Tutor in Philosophy, *New College, Oxford*; Michael Green, MA, FRCP, Consultant Physician in Geriatric Medicine, *Royal Free*; Roger Higgs, MA MB BChir MRCP, General Practitioner, *London*; The Revd Gerard J. Hughes, SJ, Head of Department of Philosophy, *Heythrop College*; Ian Kennedy, LL.M., Reader in the Faculty of Laws, *King's College, London*; Margaret Lee, SRN, RMN NA(H) Cert, Professional Officer, *Royal College of Nursing*; Professor Ian McColi, MS FRCS, Professor of Surgery, *Guy's*; Bruce MacGillivray, BSc FRCP, The Dean, *Royal Free*; Professor Neil McIntyre, BSc MD FRCP, Professor of Medicine, *Royal Free*; Professor Norman Morris, MD FRCOG, Professor of Obstetrics and Gynaecology, *Charing Cross*; Professor Thomas Oppé, FRCP DCH, Professor of Paediatrics, *St Mary's*; Professor R. G. Spector, PhD MD FRCP FRCPath, Professor of Applied Pharmacology, *Guy's*; Professor R. W. Taylor, MD FRCOG, Professor of Obstetrics, *St Thomas's*; A. G. L. Whitelaw, MD MB BChir MRCP, Consultant Neonatologist *Hammersmith*.

LONDON MEDICAL GROUP

L.M.G. Office: TAVISTOCK HOUSE NORTH, TAVISTOCK SQUARE, LONDON WC1H 9LG

STUDY SEMINARS

Convened by Ian Leonard, BSc (Guy's)

Addressed primarily to medical, nursing and other students.

Each seminar finishes at 8 pm

AN INTRODUCTION TO ETHICS

The first two seminars will provide a basic introduction to two major ethical theories — deontology and utilitarianism, whilst the third one will examine possible reasons for holding the morality of actions to be important.

Rule of Thumb or Deontology James Griffin, BA MA DPhil, Fellow and Tutor in Philosophy, Keble College, Oxford

Utilitarianism: a pragmatic approach? Jonathan Glover, MA DPhil, Tutor in Philosophy, New College, Oxford

Why act morally? Professor R. M. Hare, MA, White's Professor of Moral Philosophy, Corpus Christi College, Oxford

At 6 for 6.30 pm on Wednesdays 28th October, 4th and 11th November, 1981.

WHAT IS A PERSON?

The concept of a person is of great importance in many areas of moral reasoning. These seminars will pursue three different approaches — from philosophy, psychology, and ethology — to answering the question 'What is a person?'

What do we mean by a 'person'? Raanan Gillon, BA MB BS MRCP, Student Health Officer, Imperial College; Editor, *Journal of Medical Ethics*

What is personal about being a person? D. Bannister, BA PhD, Medical Research Council External Scientific Staff

A personal view of human nature, P. K. Smith, BA PhD Lecturer in Psychology, University of Sheffield

At 6 for 6.30 pm on Wednesdays 13th, 20th and 27th January 1982

MEDICINE IN LITERATURE

This series of seminars will examine how authors have portrayed various aspects of medical practice, with particular attention to the significance of such a portrayal for medicine.

A Fortunate Man, by John Berger. Donald Craig, MA BM BCh MRCP DObstRCOG, Honorary Lecturer, Department of General Practice, Guy's Hospital Medical School

Cancer Ward, by Alexander Solzhenitsyn. Irina Kirillova, MA, Lecturer in Slavonic Studies, Newnham College, Cambridge

The Doctor's Dilemma by George Bernard Shaw. Daniel Karlin, BA PhD, Lecturer in the Department of English Language and Literature, University College London

At 6 for 6.30 pm on Wednesdays 17th, 24th and 31st March 1982

PSYCHIATRY: PERPETUAL ECLECTICISM?

The first seminar will explore the origins of current psychiatric practice whilst subsequent ones will look critically at contemporary psychiatry and its position in relation to medicine as a whole.

The Intellectual Foundations of Psychiatry Derek Bolton, PhD, Lecturer in Psychology, Institute of Psychiatry

A Critique of Psychiatry Stephen Little, MA MB BCh MRCPsych DPM, Consultant in Child and Adolescent Psychiatry, Medway Health District

Should Psychiatry be a Part of Medicine? Michael Shepherd, DM FRCP FRCPsych DPM, Professor of Epidemiological Psychiatry, Institute of Psychiatry

At 6 for 6.30 pm on Wednesdays 19th and 26th May, and 2nd June 1982

HOW TO APPLY

LMG Study Seminars are designed for more intensive discussion of suitable topics than lectures and symposia normally allow. Four series are offered this year; they are confined to a dozen participants by application only. Participants are expected to take part in each seminar in a series. Those interested should apply to The Secretary, London Medical Group, Tavistock House North, Tavistock Square, London WC1H 9LG, enclosing a Registration Fee of £1 per series and a stamped addressed envelope.

CONFERENCES

APPROPRIATE MEDICINE

Convened by Alan Schamroth, BSc (Middlesex)

The 19th Annual Conference will examine the social, political and professional attitudes to health care. Although addressed primarily to students of medicine, nursing, law, theology and the social sciences, the conference is open to others professionally interested.

At Charing Cross Hospital Medical School, by kind permission of the Dean On Friday and Saturday 12th and 13th February 1982

TOPICS: Why are the British so Unhealthy?; Inequalities in Health; Society versus Health; Diseases of Affluence: the great medical disaster; The Politics of Medicine: The Medical Ascendancy; The Medical Model: its restrictions and limitations; Medicine for the People; The Greatest Good of the Smallest Number?; What Price Excellence?; Technological Imperialism; Great Expectations: Servant or Master?; The Autonomy of the Consultant; The Doctor should Listen; Hard Cases Make Good Doctors; Appropriate Training: Can Caring be Taught?; The Education of the Patient; Educating for Service

SPEAKERS AND CHAIRMEN WILL INCLUDE: Sir Douglas Black, Mr Denis Burkitt, Dr Anthony Clare, Lesley Doyal, Professor A. S. Duncan, Mr T. A. H. English, Professor T. W. Glenister, Professor Jack Hayward, Dr Peter Huntingford, Dr David Ingleby, Professor John Lorber, Professor Marshall Marinker, Lady McCarthy, Dame Cicely Saunders, Dr Alex Scott-Samuel, Professor R. B. Welbourn, Katharine Whitehorn, Dr Luke Zander.

Further Information and application forms from the Conference Secretary, London Medical Group, Tavistock House North, Tavistock Square, London WC1H 9LG (Closing date for applications 3rd February 1982.) Please enclose a stamped addressed envelope.

THE RIGHT TO LIVE AND THE RIGHT TO DIE

A residential week-end conference for medical, nursing and other students has been arranged by Cumberland Lodge from Friday 23rd April to Sunday 25th April 1982.

There will be a moral philosopher in residence, and speakers will represent medicine and other disciplines.

Further details and application forms from Miss Ruth Norton, Cumberland Lodge, Windsor Great Park, Windsor, Berks.

HOW TO GET TO LMG LECTURES AND SYMPOSIA

Charing Cross Hospital, Fulham Palace Road, W6.

Hammersmith (District and Piccadilly lines)

Guy's Hospital, St Thomas Street, SE1.

London Bridge (Northern)

King's College Hospital, Denmark Hill, SE5.

Elephant and Castle (Northern and Bakerloo lines) thence Buses: 12, 68.

176, 184, 185, 196

The London Hospital, Whitechapel, E1

Whitechapel (Metropolitan and District) Buses: 15, 25

The Middlesex Hospital Medical School, Cleveland Street, W1.

Warren Street (Victoria and Northern) Goudge Street (Northern) Great

Portland Street (Metropolitan and Circle)

Royal Free Hospital, Pond Street, Hampstead, NW3.

Belsize Park (Northern) Buses: 24, 46

St Bartholomew's Hospital, West Smithfield, EC1.

Farringdon or Barbican (Metropolitan and Circle) St Paul's (Central)

St George's Hospital Medical School, Cranmer Terrace, Tooting SW17.

Tooting Broadway (Northern) Buses: 44, 77, 220

St Mary's Hospital Medical School, Praed Street, W2.

Paddington (Bakerloo, Metropolitan, District and Circle) Buses: 15, 27

St Thomas's Hospital, Lambeth Palace Road, SE1

Westminster (District and Circle — walk over Westminster Bridge) Buses:

12, 53, 59, 77C, 149, 168

University College Hospital, Gower Street, WC1

Warren Street (Victoria and Northern) Euston Square (Metropolitan and

Circle) Buses: 14, 24, 29, 73

Westminster Medical School, Horseferry Road, SW1.

St James's Park (District and Circle) Fimlico (Victoria) Buses: 88 to

Horseferry Road, 3, 77, 159 to Embankment/Lambeth Bridge

Appendix 4

Topics of Lectures, Symposia and Study Seminars: Associated Medical Groups, 1981/2

1. Aberdeen Medical Group

The private medicine debate

The elderly explosion: Whom will it hurt and who cares?

Women in the NHS

Drug advertising: The place of the commercial pusher

2. Birmingham Medical Group

Abortion

Contraception: AIDS

Alternative sexuality

Terminal care

Waiting lists

Hospital management

International health service comparison

The future of the NHS

3. Bristol Medical Group

The care of the dying

Who carries the can? The individual or society's responsibility for illness

The nurse of the future

Medical confidentiality: Boon or curse?

Why not ask the patient? Patient participation in Aberdare

Women in Medicine

The future of the NHS

Survival of the concrete jungle: Inner city health

4. Cambridge Medical Group

Too busy to care

Test-tube babies

The politics of psychiatry

5. Cardiff Medical Group

Humanizing childbirth

The nature and management of terminal pain

Spina bifida: Is life worth it?

Strikes within the health service: Who really benefits?

The rights of the retarded

Male chauvinism in medicine? Male doctors and female diseases

Depression and the inner city

Patient-run health care

Disfigurement of self: The other side of the colostomy

6. Dundee Medical Group

Coronary care: Home or hospital?

Geriatric care: Do we really care?

Minimal brain damage: Its implications in 1980

Drugs and their use in the Third World

7. Edinburgh Medical Group

Is the doctor the best person to dispense advice?

Can we legislate for health?

Talking and listening to patients

Why are we here?

Women in medicine

Euthanasia: A dead issue?

Alternative medicine: Medicine before science: folk medicine; homeopathy;
faith healing

Medicine in the year 2000

8. Liverpool Medical Group

What sort of doctor do you want?

Violence in hospital

Does alternative medicine work?

Euthanasia: The right to die?

Medical audit: Is it worth the cost?

The dangers of being born

What price the pill?

9. Manchester Medical Group

ECT: An ethical form of treatment?

Cloning

Strikes: Exploited workers or neglected patients?

Problems of sub-fertility

Child abuse: The doctor's responsibility?

When and where to be born

Why not euthanasia: The right to die?

The legalization of cannabis

Self-medication: Is your doctor necessary?

Who cares for the elderly?

10. Newcastle Medical Group

Health by the people: Lessons from the Third World

Profits or patients: A debate on the relationship between
doctors and the pharmaceutical industry

Homeopathy

The violent family

Drugs and dissent

The truth, the whole truth and nothing but evasion:

What do doctors tell patients?

11. Oxford Medical Forum

Smoking: The Government's dilemma

Patients: Teaching material?

Health: Need working class equal second class?

Five years' survival or five years good life?

Conflict of loyalties: Doctors working in institutions

12. Sheffield Medical Group

Women in medicine

Birth at home

Euthanasia

Drug pushing

The right to withdraw labour

Sec education: Its practice and problems

13. Southampton Medical Group

Voluntary euthanasia: Whose death is it anyway?

Priorities in medicine: Is cancer more important than backache?

The philosophy and practice of acupuncture

Strikes: Are they killing people?

Artificial insemination by donor

Do health workers care: More competent, less human?

Faith healing: Can we expect miracles?

The relevance of Western medicine to the Third World

Appendix 5

Attendance at LMG lectures, symposia and annual conferences, 1972/3–81/2

ATTENDANCE AT LMG LECTURES, SYMPOSIA AND ANNUAL CONFERENCE FOR ACADEMIC YEARS 1972-1981												
	Average	Average	Average	Average	Average	Average	Average	Average	Average	Average	Average	Average
	1972/73	1973/74	1974/75	1975/76	1976/77	1977/78	1978/79	1979/80	1980/81	1981/82		
Hospital	95	55	134	117	124	81	199	91	95			
Charing Cross	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=3)	(n=4)	(n=4)	(n=4)	(n=4)		
Guy's	101	60	147	110	130	92	92	48	127			
	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)		
KCH	78	56	102	115	96	69	85	108	73			
	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)		
The London	101	72	125	173	98	94	69	82	112	81		
	(n=4)	(n=4)	(n=4)	(n=3)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)		
The Middlesex	104	85	62	192	130	152	239	114	86	121		
	(n=4)	(n=4)	(n=4)	(n=2)	(n=4)	(n=4)	(n=3)	(n=4)	(n=4)	(n=4)		
Royal Free	109	62	69	129	83	120	88	69	118	60		
	(n=4)	(n=4)	(n=3)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)		
St Bart's	101	102	73	98	87	93	83	87	162	281		
	(n=4)	(n=4)	(n=4)	(n=3)	(n=4)	(n=3)	(n=4)	(n=4)	(n=4)	(n=3)		
St George's	46	73	59	81	54	67	273	84	86	93		
	(n=4)	(n=3)	(n=4)	(n=4)	(n=4)	(n=3)	(n=4)	(n=4)	(n=3)	(n=4)		
St Mary's	58	56	90	99	133	69	95	95	69	76		
	(n=6)	(n=3)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)		
St Thomas's	113	59	69	162	105	103	137	202	90	113		
	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=3)	(n=4)		
UCH	123	44	153	120	114	241	132	108	110	70		
	(n=4)	(n=4)	(n=3)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)	(n=4)		
Westminster	55	80	51	98	39	140	130	134	66	75		
	(n=4)	(n=3)	(n=4)	(n=3)	(n=4)	(n=3)	(n=3)	(n=4)	(n=4)	(n=4)		
All Hospitals	86	72	76	126	99	116	124	111	96	105		
	(n=50)	(n=45)	(n=46)	(n=43)	(n=48)	(n=44)	(n=46)	(n=47)	(n=47)	(n=47)		
Annual Conference	365	425	400	425	435	370	380	429	340	340		

Note: n – numbers in parentheses (n=3) indicate the number of events from which the average figure was derived

Appendix 6

Questionnaire²⁶⁵

When did you first attend a lecture or symposium arranged by the London Medical Group?

[174 replies]

1960–69	36	21%
1970–79	105	60%
1980–89	33	19%

a) At the time, where you a pre-clinical/clinical; student nurse/nurse; or other? [179 replies]

Pre-clinical	71	40%
Clinical	105	59%
Student nurse/nurse	1	

What attracted you to attend a Medical Group lecture or symposium for the first time?

[177 replies]

Friends	21	12%
Publicity	11	6%
Topic/speaker	117	66%
Other	28	16%

Did you attend:

a) medical group lectures regularly/occasionally? [158 replies]

Regularly	121	(77%)
Occasionally	37	(23%)

b) the annual conference in London? [159 replies]

Yes	72	45%
No	87	55%

Was there any other source of teaching or learning about medical ethics? Either in the curriculum or extra-curricular? [166 replies]

Yes	29	17%
No	137	83%

²⁶⁵ The cohort of doctors who could receive the questionnaire was limited to those who were trained at the then 12 London medical schools and involved in the LMG. See further details on page 72.

Can you recall any medical group topic or lecturer which or whom you regarded as particularly significant? [30% of all respondents could recall neither] [180 replies]

Saunders	31
Others	63
Topic	32
Can't remember	54

Do you have any views on positive/negative aspects of the way the Medical Group was organized (student representative council and senior consultative council)? [178 replies]

Yes, positive	98	89% of those who expressed a view were positive
Yes, negative	12	
No	68	

a) the way topics were identified by students? [177 replies]

Yes, positive	65	90% of those who expressed a view were positive
Yes, negative	7	
No	105	

b) the way lecturers were suggested? [168 replies]

Yes, positive	51	93% of those who expressed a view were positive
Yes, negative	4	
No	113	

With hindsight what were the strengths and weaknesses of the medical group method? [179 replies]

Strengths:

Speakers	24	13%
Purpose	47	26%
Topics	15	8%
Other	39	22%
Not sure; can't remember	55	31%

In your view, how successful was the Medical Group as:

a) a multidisciplinary forum? [177 replies]

Very	94	53%
Quite	50	28%
Not	33	19%
No reply	17	

b) an introduction to medical ethics? [176 replies]

Very	134	76%
Quite	28	16%
Not	6	3%
Not sure	8	5%
No reply	3	

Did your involvement with the Medical Group influence your subsequent career? [176 replies]

Yes, specific	18	10%
Yes, non-specific	68	39%
No	74	42%
Not sure	16	9%
No reply	3	

a) What, if any, involvement do you have with medical ethics? [173 replies]

Yes, specific	59	34%
Yes, non-specific	79	46%
No	30	17%
Not sure	5	3%
No reply	6	

In your view, what influence, if any, have the Medical Groups and their method had on:

a) undergraduate medical education? [168 replies]

Positive	88	52%
Negative	14	8%
Not sure	66	39%
No reply	18	

b) postgraduate medical education? [146 replies]

Positive	42	29%
Negative	13	9%
Not sure	91	62%
No reply	30	

c) medical practice? [152 replies]

Positive	60	39%
Negative	5	3%
Not sure	87	57%
No reply	25	

d) public debate on issues raised by the practice of medicine? [136 replies]

Positive	35	26%
Negative	6	4%
Not sure	95	70%
No reply	42	

e) In your opinion, are there any lessons to be learned from the medical group method in today's teaching of medical ethics? [143 replies]

Yes	96	67%
No	4	3%
Not sure	43	30%
No reply	28	

Appendix 7

London Medical Group Presidents, 1963–89

1963-65	Margaret Rose	St Marys
1965-66	Andrew Chapman	Middlesex
1966-67	Brian Cutler BA	St Bartholomew's
1967-68	Roger Higgs BA	Westminster ⁴
1968-69	Peter Wilkinson BA	KCH
1969-70	John Bull BA	St Thomas's
1970-71	Norman Beale BA	St Mary's
1971-72	Jeremy Queenborough	Charing Cross
1972-73	Jeremy Berry BA	Middlesex
1973-74	Simon Walford BA	The London
1974-75	John Sedgwick MA	St Thomas's
1975-76	Tim Helme BA	Middlesex
1976-77	Dorian Haskard BA	Middlesex
1977-78	Ian Kunker BA	St Bartholomew's
1978-79	Stephen Krickler BSc	Middlesex
1979-80	Martin Waldron	Royal Free
1980-81	Patrick Magee MSc	Westminster
1981-82	Alan Schamroth BSc	Middlesex
1982-83	Gerald Smith BSc	St Bartholomew's
1983-84	Lanil de Silva BSc	KCH
1984-85	Paul Kelly BA	The London
1985-86	Guy Watkins BA	St Bartholomew's
1986-87	Timothy Gluck	UCH
1987-88	Jeremy Levy	The London
1988-89	Helen Sherrell RGN	Middlesex

Margaret Rose was Secretary and Andrew Chapman, Brian Cutler and Roger Higgs were Chairmen of the Group.

Appendix 8

Donations to the LMG and the Institute of Medical Ethics

DONATIONS TO THE LONDON MEDICAL GROUP 1967 - 1988

Her Majesty The Queen
The Goldsmiths' Company
St Edmund King & Martyr Trust
Discovery Foundation
Sir Halley Stewart Trust
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Chapel Royal, St James's Palace
Parochial Church Council of All Saints, Weston
Parochial Church Council of St Mary and St James, Grimsby
Round Table, Grimsby
Round Table, Plymouth
Rotary Club, Cleethorpes
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University College Special Trustees
Guy's Hospital Medical School
Guy's Hospital Special Trustees
Westminster Hospital Medical School
Westminster Hospital Special Trustees
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King's College Hospital Special Trustees
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We are also grateful for donations from the many individuals who supported the London Medical Group from its inception, whose names are listed in earlier reports.

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Esmee Fairbairn Charitable Trust
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The Leverhulme Trust

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The Nuffield Foundation

Life Before Birth

All Saints Educational Trust

Ethics of Using Animals in Medical Research

The Leverhulme Trust

Ethics in Nursing

The King Edward VII Hospital Fund for London

Briefings in Medical Ethics

The Leverhulme Trust

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Ethics of Using Animals in Medical Research

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Appendix 9

Attendance at 104 lectures and symposia by topics, 1971/2

<i>Topic</i>	<i>Number of lectures/symposia</i>	<i>Average Attendance</i>
GROUP A: Organisation of medicine	6	67
Doctor-patient relationship	5	64
GROUP B: Death, dying, terminal pain	17	107
Euthanasia	2	160
Geriatrics	5	61
GROUP C: Drugs, addiction, alcoholism	6	137
Drug industry, testing etc.	4	41
GROUP D: Fertility, contraception and sterilization	13	55
Abortion	2	215
GROUP E: Medico-legal	6	57
Psychiatry and religion	5	96
Ethics, decision-making	4	52
Social questions	6	42
GROUP F: Sexually transmitted diseases	4	69
Human sexuality	6	73
Touch in human relations	3	130
Marital breakdown	3	95
GROUP G: Mental illness	4	51
Mental health of the doctor	3	40

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Biographical notes*

Basil William Sholto Mackenzie, Baron Amulree
 KBE MD FRCP (1900–83), qualified at Cambridge and trained in Paris and at University College Hospital (UCH), was Assistant Pathologist at UCH, 1929–31 and at the Royal Northern Hospital, 1931–36. He was a Medical Officer at the Ministry of Health, 1936–50 and Physician at UCH, 1949–66, and Liberal Whip in the House of Lords, 1955–77. He also served as Chairman of the Attendance Allowance Board, 1970–76; President of the London County Division of the British Red Cross, 1945–60; the Association of Occupational Therapists, 1956–60; the Society of Chiropractors, 1963; the Association of Welfare Officers, 1960–68; the British Geriatric Society, 1949–65; and Chairman of Invalid Meals for London, 1956–59; and Chairman of the Governing Body of the London Medical Group, 1968–81. See also Denham (2005); Dunstan (1984); Figure 1.

Professor Tom Arie
 CBE FRCPsych FRCP FFPH (b. 1933) qualified in Oxford and trained in psychiatry at the

Maudsley Hospital and in social medicine with Professor J N (Jerry) Morris at the MRC Social Medicine Unit at the London Hospital. He was Foundation Professor of Health Care of the Elderly at Nottingham University until 1995, later Emeritus. As one of the first old-age psychiatrists, he has been chairman of the Old Age Faculty of the Royal College of Psychiatrists, and of the Geriatric Psychiatry Section of the World Psychiatric Association.

Dr Ian Bailey
 FRCP (1928–97) qualified at Manchester, and after house officer posts at the Manchester Royal Infirmary his compulsory military service in the RAMC was spent at the Royal Herbert Hospital, Woolwich, London. His medical registrar post was at University College Hospital and the Whittington Hospital, London, followed by his appointment in 1963 as consultant physician to Southmead Hospital, Bristol, where he was a general physician with an interest in gastroenterology until his retirement. He helped the Bristol medical students to

* Contributors are asked to supply details; other entries are compiled from conventional biographical sources.

found their own academic society, the Bristol Medical Group in 1975. See www.rcplondon.ac.uk/heritage/munksroll/munk_details.asp?ID=179 (visited 19 July 2007).

Professor Sir Dugald Baird

Kt FRCOG (1899–1986), obstetrician and gynaecologist and early exponent of abortion, was Regius Professor of Midwifery at the University of Aberdeen from 1937 until 1965, formerly Obstetrician-in-Chief at the Aberdeen Maternity Hospital and Visiting Gynaecologist at the Aberdeen Royal Infirmary. He directed the MRC's Obstetric Medicine Research Unit there from 1955 until his retirement. See Thomson (1975): 93–4; Howie (1987).

Dr Michael Balint

(1896–1970), a Hungarian psychoanalyst, was born as Mihály Maurice Bergmann and emigrated to Britain in the 1930s. He practised as a psychoanalyst at the Tavistock Clinic, London, from 1948 until his retirement in 1961. He is best known to general practitioners for his work in the 1950s and 1960s in helping them to understand the psychology of the doctor–patient relationship. See Balint (1957); Lakasing (2005). For background details of Balint's work with general practitioners, see Reynolds and Tansey (1998): 126–9; 174.

Dr Michael Barr

PhD (b. 1969) is the Research Councils' UK Fellow at the Policy, Ethics and Life Sciences Research Centre (PEALS), University of Newcastle. From 2004–06 he worked in the BIOS Centre at the London School of Economics on a variety of bioethical issues in psychiatry, pharmacogenetics and biobanking. He has published on the historical, philosophical and sociological aspects of biomedical ethics [Barr (2003) published as Whong-Barr] and will guest edit a special issue of the journal *Bioethics* on the Bioethics of Security in 2007.

Dr Henry Beecher

(1904–76) qualified at Harvard Medical School, and in 1936 was appointed Anesthetist-in-Chief at Massachusetts General Hospital, Boston, MA, becoming Professor of Anesthesiology at Harvard University in 1941. Beecher's first major publication on research ethics appeared in the *Journal of the American Medical Association (JAMA)* in 1959, followed by a review of 18 examples of clinical research that he deemed unethical. After critical remarks by colleagues, he sent additional examples to *JAMA* in 1965, which were rejected. Beecher's re-structured paper analysing 22 cases was published by the *New England Journal of Medicine* in 1966. He

suggested that an ethical approach to human experimentation should include: obtaining informed consent from the participant; providing an intelligent, informed, conscientious, compassionate and responsible investigator; and that the benefits gained from the research be commensurate with the risk [Beecher (1966)] and later led to the establishment of institutional review boards in the US, and research ethics committees in the UK. Newspaper clippings related to the Nuremberg Medical Trial exist in Beecher's personal papers in the Special Collections Department, Countway Library, Harvard University. See Greene (1976); Kopp (1999).

The Revd Tony Birbeck

MBE (b. 1933) was trained at the Lincoln Theological College and ordained Deacon in 1960 and Priest in 1961. He was Canon Res and Treasurer at Wells Cathedral from 1974–78; Non-stipendary Minister of Wells St Thomas with Horrington 1989–98; retired 1998; Permission to Officiate, (Diocese of) Bath and Wells, from 1998.

Professor Sir Douglas Black

Kt FRCP FRCPsych FRCOG (1913–2002) qualified at St Andrews University in 1936 and held clinical and research posts in Dundee, Oxford and Cambridge

and was an MRC Research Fellow from 1938 to 1940 and a Beit Memorial Research Fellow from 1940 to 1942. He served with the Royal Army Medical Corps from 1942 to 1946. He was appointed to the Department of Medicine at Manchester University in 1946, becoming Professor of Medicine from 1959 to 1977, later Emeritus. He was Chief Scientist at the Department of Health and Social Security from 1973 to 1977, a member of the MRC from 1966 to 1970 and 1971 to 1977; Chairman of the MRC Clinical Research Board from 1971 to 1973, Chairman of the Research Working Group on Inequalities in Health from 1977 to 1980 and President of the Royal College of Physicians from 1977 to 1983, and of the Institute of Medical Ethics, 1984–2002. See Department of Health and Social Security (1980).

Professor Sidney Bloch

PhD DPM FRCPsych FRANZCP DipPhilMed (b. 1941) graduated in Medicine from the University of Cape Town and trained in psychiatry in the University of Melbourne, the Maudsley Hospital, and Stanford University, California. He spent 13 years in the University of Oxford's Department of Psychiatry, when he was appointed Associate Professor and Reader in the University of Melbourne in

1989 and full professor in 1999, and Adjunct Professor at the Centre for the Study of Health and Society there. He was a member of the Ethics Committee, Royal Australian and New Zealand College of Psychiatrists (1989–2002); and served on the Royal College of Psychiatrists' Committee on Psychiatric Abuse (1978–88). He served as Editor of the *Australian and New Zealand Journal of Psychiatry* (1992–2004) and Associate Editor of the *British Journal of Psychiatry* (1978–88).

Professor Sir Christopher Booth Kt FRCP (b. 1924) trained as a gastroenterologist and was Professor of Medicine at the Royal Postgraduate Medical School, Hammersmith Hospital, London, from 1966 to 1977 and Director of the Medical Research Council's Clinical Research Centre, Northwick Park Hospital, Harrow, from 1978 to 1988. He was the first Convenor of the Wellcome Trust's History of Twentieth Century Medicine Group, from 1990 to 1996, and Harveian Librarian at the Royal College of Physicians from 1989 to 1997.

Professor Kenneth Boyd PhD FRCP Ed (b. 1939) was Scottish Secretary of the SCM, 1964–69; Associate Chaplain at the University of Edinburgh, 1969–75; Research Fellow in Medical Ethics and Education at the University of Edinburgh, 1975–80; Research Director of the Institute of Medical Ethics from 1980 until 2005. He was Honorary Fellow (1990–95) and Senior Lecturer (1996–2002) in Medical Ethics, Faculty of Medicine at the University of Edinburgh. He has been Professor of Medical Ethics at the College of Medicine and Veterinary Medicine, University of Edinburgh, since 2002; General Secretary of the Institute of Medical Ethics, since 1998; Chair of the Boyd Group on the Use of Animals in Science, since 1992; and Deputy Editor of the *JME* since 2000.

Fr Brendan Callaghan SJ MA MPhil MTh (b. 1948) is a Jesuit and a Roman Catholic priest, who worked with the Medical Groups and the Institute of Medical Ethics from 1976, and was General Secretary from 1998 to 2002. He lectures in the Psychology of Religion at Heythrop College, University of London, where he was Principal from 1985 to 1997.

Professor Alastair Campbell

MA BD ThD (b. 1938) studied philosophy and then divinity at the University of Edinburgh, followed by doctoral studies at the Graduate Theological Union, San Francisco. While an Associate Chaplain to the University of Edinburgh (1964–9), he was a part-time Lecturer in Ethics, Royal College of Nursing, Scotland (1966–72), resulting in the first modern textbook in medical ethics [Campbell (1972)]. He was a joint secretary with Kenneth Boyd of the Edinburgh Medical Group; foundation editor of the *JME* (1975–80); Associate Dean, Faculty of Divinity, Theology, University of Edinburgh (1987–90); Professor of Biomedical Ethics, Otago Medical School, New Zealand (1990–96) and Professor of Ethics in Medicine, University of Bristol (1996–2006). He has been Chen Su Lan Centennial Professor of Medical Ethics and Director of the Centre for Biomedical Ethics at the Yong Loo Lin School of Medicine, National University of Singapore since August 2006. He is a past President of the International Association of Bioethics, and has been a member of the Medical Ethics Committee of the British Medical Association, Vice-Chairman of the UK Retained Organs Commission (2001–04) and Chairman of the Ethics

and Governance Council of UK Biobank (2005/6). See Figure 2.

Sir Iain Chalmers

FRCPE FFPH FMedSci (b. 1943) has been Editor of the award-winning James Lind Library since 2003. He was Director of the UK Cochrane Centre in Oxford from 1992 to 2002 and Director of the National Perinatal Epidemiology Unit, Oxford, from 1978 to 1992. See www.jameslindlibrary.org/ (visited 1 August 2007).

Professor Stephen Clark

DPhil (b. 1945) has been Professor of Philosophy at the University of Liverpool since 1983, and a member of the Farm Animal Welfare Council from 1996 to 2002. He was a member of the committee to consider the Ethical Implications of Emerging Technologies in the Breeding of Farm Animals (the Banner Committee) and a member of the Home Office's Animal Procedures Committee. See MAFF (1995, 1998); Home Office (2001).

Dr Hugh Clegg

CBE FRCP (1900–83) qualified at Cambridge and Bart's with house jobs in the Brompton and Charing Cross Hospitals, London, joining the *BMJ* in 1929, where he was appointed editor in 1947. He sponsored the first two world conferences on

medical education and became involved with the World Medical Association and medical ethics, and his work contributed to the Declaration of Helsinki on human experimentation. See Lock (1984).

Dr Christine (Tina) Cooper OBE DCH FRCP (1918–86), paediatrician and expert on child abuse, went to a finishing school and was later trained as a nursery nurse, neither of which was a suitable foundation for a medical career. Following a year's preparation at a crammer, she was accepted at Girton College Cambridge in 1939, qualified in 1945, trained and held junior posts at the Royal Free Hospital, London, before moving, in 1949, to Newcastle upon Tyne as senior registrar to Professor James Spence in the new Department of Child Health (the first department in England, created in 1942 and supported by the Nuffield Foundation) at Newcastle General Hospital. She was appointed consultant there in 1952 until her retirement in 1983. See Cohen (2004), also available online at www.oxforddnb.com/view/article/60895 (visited 6 August 2007).

Professor Donna Dickenson PhD (b. 1946) founded and directed the University of Birmingham's Centre for the Study of Global Ethics. She chaired the

Open University course on 'Death and Dying', which reached some 10 000 doctors and nurses between 1993 and 1997. As Leverhulme Reader in Medical Ethics and Law at Imperial College, London, from 1997 to 2001, she oversaw the design of a comprehensive undergraduate ethics programme and the creation of an MSc in Medical Ethics and Law. She was Professor of Medical Ethics and Humanities at Birkbeck, University of London, from 2004 to 2006, later Emeritus, and Executive Director of the Birkbeck Institute for the Humanities. She also chaired the European Commission's medical ethics teaching projects, European Biomedical Ethics Practitioner Education (EBEPE) and Teaching Ethics: Material for Practitioner Education (TEMPE), which resulted in an influential textbook [Parker and Dickenson (2001)]. In 2006 she won the international Spinoza Lens award for contribution to public debate on ethics, the first woman to have received the award.

Professor Robert Silcock Downie FRSEd FRSA (b. 1933) was appointed Lecturer in Moral Philosophy, University of Glasgow, in 1959; Senior Lecturer in 1968, and Professor of Moral Philosophy from 1969 until 2002, later Emeritus. He was Stevenson

Lecturer in Medical Ethics, University of Glasgow, 1984–88; Visiting Professor of Philosophy, Syracuse University, NY, 1963/4. He has been Honorary Professorial Research Fellow, Glasgow University, since his retirement in 2002. He was a Member of the Advisory Committee on Genetic Testing (ACGT) until 1997. See Downie (ed.) (1994); Downie and Macnaughton (1998); Downie (2003).

Professor Archibald Duncan
 DSc FRCSE FRCOG FRCPE (1914–92), qualified at the University of Edinburgh and served with the Forces in the Second World War. He was appointed Lecturer at the University of Edinburgh, and was part-time Consultant Obstetrician and Gynaecologist, Aberdeen, from 1946 to 1950; Senior Lecturer there and Obstetrician and Gynaecologist to the Western General Hospital, Edinburgh, 1950 to 1953; Professor of Obstetrics and Gynaecology in the Welsh National School of Medicine, University of Wales, and Consultant Obstetrician and Gynaecologist, United Cardiff Hospitals, from 1953 to 1966 as well as Adviser in Obstetrics and Gynaecology to Welsh Hospital Board. He was Executive Dean of the Faculty of Medicine and Professor of Medical Education,

University of Edinburgh, from 1966 until his retirement in 1976, later Emeritus. He was a member of the Clinical Research Board of the MRC, 1965–69; the Council of the GMC, 1974–78; and the Lothian Health Board, 1977–83, and Vice-Chairman, 1981–83. He was Vice-President of the Institute of Medical Ethics, 1985–92; Honorary President of the British Medical Students Association, 1965/6 and Associate Editor of the *British Journal of Medical Education*, 1971–75 and Consulting Editor of the *JME*, 1975–81.

The Revd Professor Gordon Reginald Dunstan

CBE HonDD HonLLD FSA HonFRCP FRCOG HonFRCGP (1917–2004) graduated in history from the University of Leeds and trained for the priesthood at the Mirfield Fathers' College of the Resurrection in Yorkshire and was ordained in 1941. In 1955 he became Secretary of the Church of England (CoE) Council for Social Work and a minor canon at St George's Chapel, Windsor, and then at Westminster Abbey, London. He was secretary to the group that prepared a report for the 1958 Lambeth Conference, which led to the acceptance of contraception; a member of a group whose report proposed the irretrievable

breakdown of marriage as the sole grounds for divorce. He was the first holder of the F D Maurice Chair of Moral and Social Theology, King's College, London, from 1967 to 1982, later Emeritus, and Chaplain to the Queen (1976–87). He was responsible for several reports from the CoE Board for Social Responsibility (1962, 1965a and b). See also Shotter (2004); Figure 4.

Professor Johannes Fibiger (1867–1928) qualified as a doctor in 1890, studied under Koch and Behring and received his doctorate for his work on the bacteriology of diphtheria at the University of Copenhagen in 1895, subsequently appointed prosector at the University's Institute of Pathological Anatomy (1897–1900), and Professor of Pathological Anatomy at Copenhagen University and Director of the Institute of Pathological Anatomy. He was awarded the 1926 Nobel Prize for Physiology or Medicine for his discovery of the Spiroptera carcinoma. See Hrobjartsson *et al.* (1998).

Professor Charles Fletcher CBE FRCP (1911–95) was Professor of Clinical Epidemiology at the Royal Postgraduate Medical School, Hammersmith Hospital, London, from 1973 to 1976, later Emeritus, and Physician to

the Hammersmith Hospital from 1952 to 1976. He directed the MRC Pneumoconiosis Research Unit from 1945 to 1952 and was Secretary of the MRC Committee on Bronchial Research from 1954 to 1976. He was a member of the Council of the Royal College of Physicians from 1959 to 1963 and Secretary to their Committee on Smoking and Health from 1961 to 1967. See Booth (1998). See also a videotape interview with Professor Charles Fletcher by Max Blythe, held at the Royal College of Physicians of London.

Dr Fritz Fuchs (1918–95) a Danish obstetrician, later Professor at Cornell University, New York, NY.

Mrs Iris Fudge NNEB SRN (b. 1927) trained as a Nursery Nurse in 1944, completed General Nursing training at King's College Hospital, London in 1947, qualifying as a State Registered Nurse in 1950. From 1952 she nursed at the King's College Hospital Department of Psychological Medicine until 1957. She has been a Fellow of the Royal Anthropological Institute since 1984 and a Committee Member of the Higher Education Network for Research and Information in Psychoanalysis (THERIP).

Professor K W M (Bill) Fulford
 DPhil PhD FRCP FRCPsych
 (b. 1942) was appointed Clinical Lecturer in the Psychiatry Department, University of Oxford, in 1977, and has been Honorary Consultant, Department of Psychiatry at the University of Oxford since 1983, and faculty member, Faculty of Philosophy there from 2007; Professor of Philosophy and Mental Health, University of Warwick since 1995; Special Adviser for Values-Based Practice, Department of Health since 2003; and Professor and Co-Director of the Institute for Philosophy, Diversity and Mental Health at the University of Central Lancashire from 2006. With Professor Tony Hope, he directed the Oxford Practice Skills Programme from 1990 to 1995; founded and has been co-editor of the journal *Philosophy, Psychiatry and Psychology* since 1993; and was editor of the Oxford University Press book series, *International Perspectives in Philosophy and Psychiatry*, since 2003 and of the Cambridge University Press book series on values-based medicine from 2007.

Professor Stanley Gelbier
 HonFFPH FDS DDPH
 (b. 1935) was Area Dental Officer in Lambeth, Southwark and Lewisham (1974–80), Senior Lecturer and later Professor of

Dental Public Health (1980–2002), Head of the Division of Oral Health Services Research at King's College London (1998–2000) and Honorary Consultant in dental public health to a number of health authorities (1983–2002). He is a past President of the British Association for the Study of Community Dentistry and past Chairman of the Specialist Advisory Committee in Dental Public Health (1980–2). He was the first dentist to gain an Honorary Fellowship from the Faculty of Public Health and was awarded the Tomes Medal by the British Dental Association in 2002.

Professor Michael Gelder
 FRCP FRCPsych DPM FMedSci
 (b. 1929) educated Queen's College, Oxford, trained in psychiatry, UCH, London, and the Maudsley Hospital, London. He was MRC Fellow in Clinical Research, 1962/3, appointed Senior Lecturer at the Institute of Psychiatry, University of London, 1965–67 (Vice-Dean, 1967/8), and Physician, Bethlem Royal and Maudsley Hospitals, 1967/8; Honorary Consultant Psychiatrist, Oxford Regional Health Authority (later District Health Authority (DHA)), 1969–96; member of the Oxford DHA, 1985–92; Director of the Oxford Mental Health Care NHS Trust, 1993–97. He directed

the WHO Collaborating Centre, 1994–96; was a member of the Medical Research Council, 1978/9 (Chairman, 1978/9), and member of the MRC Neurosciences Board, 1975–78 and 1987–90. He was Chairman of the Wellcome Trust Neuroscience Panel (1990–95) and member (1984–88). He was Chairman of the Association of University Teachers of Psychiatry (1979–82) and of the Joint Committee on Higher Psychiatric Training (1981–85); an Adviser to WHO (1992–2001) and a Founder member of the Academy of Medical Sciences, 1998.

Professor Raanan Gillon

FRCP HonDSc(Oxon) (b. 1941) general medical practitioner and philosopher, was Professor of Medical Ethics at Imperial College London from 1995 to 1999, later Emeritus. For many years he combined the directorship of the Imperial College Health Centre, various academic posts in medical ethics and editorship of the *JME* (1980–2001). He joined Ted Shotter's outfit in the 1970s as an assistant director and the Institute of Medical Ethics (IME Governing Body) in 1989, becoming Chairman in 2000. His one-week intensive introductory course on medical ethics, founded in 1983, is still going strong each September at Imperial College London.

Professor Jonathan Glover

is Director of the Centre of Medical Law and Ethics at King's College London. He chaired a European Commission Working Party on Assisted Reproduction. He is interested in questions raised by the Human Genome Project. He is currently interested in a number of issues in global ethics and in ethical issues in psychiatry, and has written several books on ethics, including Glover (1977, 1999).

Sir John Muir Gray

Kt CBE MD FRCP FRCPSGlas FFPH (b. 1944) qualified at the University of Glasgow and trained in public health at Bristol. After house jobs he joined the City of Oxford as Senior Medical Officer, 1972–74; Public Health Specialist, Oxfordshire HA, 1974–91; Director, Health Policy and Public Health, Oxford RHA, 1991–94; Director of R&D, Anglia and Oxford RHA, then Anglia and Oxford Regional Office, NHS Executive, Department of Health (DoH), 1994–98; Director of the Institute of Health Sciences, University of Oxford, 1999–2002. He was co-ordinator of the National Breast Cancer Screening Programme, 1988–91; National Cervical Screening Programme, 1988–94; and Adviser, WHO, 1984–91. He has been Programmes Director, UK National Screening

Committee, since 1995, and Director of Clinical Knowledge, Process and Safety, Department of Health, since 2004. See Muir Gray (1997, 2004).

Professor Richard Mervyn Hare FBA (1919–2002), following war service and as a prisoner of war in Singapore and Siam [Burma], he was appointed a Fellow and Tutor in Philosophy at Balliol College, Oxford, from 1947 to 1966; and White's Professor of Moral Philosophy, University of Oxford, and Fellow of Corpus Christi College, Oxford, from 1966 to 1983 (Hon. Fellow, 1983), later Emeritus. Among many others, he served as a member of the Church of England Working Parties on Medical Questions, 1964–75; Honorary Fellow at the Institute of Life Sciences, Hastings Center, 1974. His work includes *Hare* (1952, 1963, 1981, 1993).

Professor Roger Higgs MBE FRCP FRCGP (b. 1943) qualified at Westminster Medical School in 1966, being LMG President in 1967/8. He took over a single-handed practice after some years as medical registrar, developing the practice into a modern group, and was a general practice principal in Walworth Road, London, from 1975 to 2004.

He founded the Department of General Practice and Primary Care at King's College, London, in 1981, and was its first lecturer, then senior lecturer, and Professor at King's [known as Guy's, King's and St Thomas' School of Medicine since 2003, although the merger took place in 1998], from 1987 to 2004. He led a group which established Lambeth Community Care Centre, the first inner-city GP hospital, and set up primary care development in southeast London and in Accident and Emergency Departments in hospitals. He was case conference editor of the *JME* and has been Chair of the Editorial Board of the journal, and vice-chair of the Ethics and Governance Committee of UK Biobank since 2005.

Sir Austin Bradford Hill FRS (1897–1991), medical statistician, was Professor of Medical Statistics at the London School of Hygiene and Tropical Medicine from 1945 until 1961. A series of 17 articles published by him in the *Lancet* in 1937 introduced the medical researcher to the use of statistics, later reprinted as *Hill (1937)*. His first attempts to introduce the concept of randomization in controlled trials were for the MRC. See *Wilkinson (1997)*.

Professor R A (Tony) Hope
PhD FRCPsych (b. 1951) had a Rhodes Travel Scholarship in 1969, undertook doctoral research in neurobiology at the National Institute for Medication Research (NIMR), London, 1973–76; trained at the Middlesex Hospital, London, and the University of Oxford; and held house positions at the Royal United Hospital, Bath, 1980/1 and the John Radcliffe Hospital, Oxford, 1981. He was a Wellcome Trust Training Fellow in Psychiatry at Oxford hospitals, 1985–87; Clinical Lecturer in Psychiatry, University of Oxford, 1987–90 and led the Oxford Practice Skills Project, 1990–95. He was Lecturer in Practice Skills, 1995–2000; Reader in Medicine, 1996–2000 and Director, Ethox (Oxford Centre for Ethics and Communication in Health Care Practice), 1999–2005. He has been Professor of Medical Ethics, University of Oxford, since 2000 and Honorary Consultant Psychiatrist at the Warneford Hospital, Oxford, since 1990. See Hope (2004); Hope *et al.* (1996).

Dr Ivan Illich
PhD (1926–2002) obtained his doctorate in history at the University of Salzburg and moved to New York in 1951, where he served as assistant pastor in an

Irish–Puerto Rican parish. From 1956 to 1960 he was Vice-Rector to the Catholic University of Puerto Rico, where he organized an intensive training centre for American priests in Latin American culture. Illich was co-founder of the Center for Intercultural Documentation (CIDOC) in Cuernavaca, Mexico, and from 1964 he directed research seminars on institutional alternatives in a technological society, with a special focus on Latin America. Known for his critique of modernization and the corrupting impact of institutions, his concerns dealt with deschooling, learning webs and the disabling effect of professions. See Smith (2001); Scott-Samuel (2003). See also www.infed.org/thinkers/et-illic.htm (visited 12 June 2007).

Sir Donald Irvine
CBE FRCGP FRCP FMedSci (b. 1935), a general practitioner in Northumberland for 35 years, also Regional Adviser for General Practice at the University of Newcastle upon Tyne and Chairman of the Council of the Royal College of General Practitioners from 1983 to 1985. He was elected President of the General Medical Council in 1995, the first general practitioner to hold that office.

Professor Bryan Jennett
 CBE MD FRCS (b. 1926)
 was appointed Lecturer in
 Neurosurgery at the University of
 Manchester from 1957 to 1963;
 Rockefeller Fellow at the University
 of California at Los Angeles
 (UCLA); appointed Consultant
 Neurosurgeon in Glasgow in
 1963, and became Foundation
 Professor of Neurosurgery,
 University of Glasgow in 1968.
 He was a Member of the Medical
 Research Council (1974–77);
 Dean of the Faculty of Medicine
 (1981–85); President of the Section
 of Neurology, Royal Society of
 Medicine (1986/7); and President
 of the International Society of
 Technology Assessment in Health
 Care (1987–89).

Professor Albert Jonsen
 PhD (b. 1933) received his
 doctorate from the Department of
 Religious Studies, Yale University
 in 1967, taught in the Departments
 of Philosophy and Theology of
 the University of San Francisco,
 where he was later President,
 and moved to the School of
 Medicine, University of California,
 San Francisco, as Chief of the
 Division of Medical Ethics, from
 1972 to 1987. He moved to the
 School of Medicine, University of
 Washington, as Professor of Ethics
 in Medicine and Chairman of the
 Department of Medical History

and Ethics from 1987–99, later
 Emeritus. He was Chair of the
 National Advisory Board on Ethics
 and Reproduction (1991–96)
 and a member of the National
 Research Council Committee on
 AIDS Research (1987–92); served
 as Commissioner on the National
 Commission for the Protection of
 Human Subjects of Biomedical and
 Behavioral Research (1974–78) and
 on The President’s Commission
 for the Study of Ethical Problems
 in Medicine (1979–82). His book
 [Jonsen (1998)] provided one of
 the first accounts of the history
 of US bioethics. See, for example,
 Jonsen (1968) and Jonsen and
 Toulmin (1988). For further
 details, see http://depts.washington.edu/mhedept/facres/aj_bio.html
 (visited 7 June 2007).

Professor Sir Ian Kennedy
 KT LLD FBA (b. 1941) is a lawyer
 who has lectured and written on
 the law and the ethics of healthcare
 in the past few decades. He gave
 the Reith Lectures in 1980. He has
 been Chairman of the Healthcare
 Commission since 2004 and was
 Professor of Health Law, Ethics
 and Policy at the School of Public
 Policy, UCL, from 1997 to 2001,
 later Emeritus, and Visiting
 Professor at the London School
 of Economics. A former Dean
 of School of Law, King’s College
 London, 1989–92 and 1993–96;

and President of the Centre of Medical Laws and Ethics, 1993–97, which he founded in 1978. He was a member of the General Medical Council (GMC) for nine years and has been a member of the Medicines Commission and Department of Health's advisory group on AIDS. He chaired the Secretary of State for Health's Advisory Group on Ethics of Xenotransplantation, 1996–97; the Minister of Agriculture's Advisory Group on Quarantine, 1997–98; the Public Inquiry into Paediatric Cardiac Surgical Services at Bristol Royal Infirmary, 1998–2001. See Kennedy (1981).

Dr Stephen Lock

CBE MA MD FRCP (b. 1929) qualified from Cambridge and St Bartholomew's Hospital Medical School, London, in 1953, and worked initially as a clinical haematologist before joining the staff of the *BMJ*, serving as its editor in 1975–91 and taking a particular interest in peer review and scientific misconduct. Since retiring, he has worked in Australia, Netherlands and the Nordic countries, as well as at the Wellcome Institute for the History of Medicine [the Wellcome Trust Centre for the History of Medicine at UCL since 2000], and has edited *The Oxford Illustrated Companion to Medicine*. His latest writings

are three chapters on Janacek's health in John Tyrrell's magisterial biography of the Moravian composer. See Lock (2006).

Professor Sir Malcolm Macnaughton

MD LLD FRCP (Glas.) FRCOG FFFP FRSE (b. 1925) qualified at the University of Glasgow, was Senior Lecturer in Obstetrics and Gynaecology at St Andrews and Dundee Universities between 1961 and 1970, when he was appointed Professor of Obstetrics and Gynaecology at the University of Glasgow until his retirement in 1990. He was President of the Royal College of Obstetrics and Gynaecology, 1984–87; a member of the Warnock Committee of Inquiry into Human Fertilization and Embryology, 1982–84; and has published widely on reproductive endocrinology and perinatal mortality.

Dr Diana Manuel

PhD was an academic at the University of Durham from 1968 to 1992 and has been a Senior Research Fellow at the Wellcome Trust Centre for the History of Medicine at UCL since 1992. She has supervised special study modules in the History of Medicine for final year medical students since 1995 in Queen Mary University of London, in Bart's and the Royal

London Hospital and from 2004 for phase 1 MBBS students at UCL. She is a committee member of the UCL Access Committee, the Friends Trust and a member of the Academic Senior Common Room committee. She established the Old Students Association (OSA) Scholarship Fund in UCL and annually supervises the award of five scholarships for £1500.

Professor Thomas McKeown PhD DPhil MD FRCP (1912–88), medical historian and exponent of social medicine, was educated at the University of British Columbia, McGill University and, as a Rhodes Scholar, Trinity College, Oxford. He became Poulton research scholar and demonstrator in physiology at Guy's Hospital Medical School working in endocrinology. During the Second World War he investigated the effects of bombing under Solly Zuckerman for the Ministry of Home Security. In 1945 McKeown was appointed to the new chair of social medicine at the University of Birmingham where he remained until his retirement in 1977; serving as Pro-Vice-Chancellor in 1974–77. He was joint editor with Lancelot Hogben and Ian Taylor of the *British Journal of Preventive and Social Medicine* (1950–58). He questioned the profession's belief that health

benefits and the reductions in mortality during the previous century arose from clinical practice, pointing to social, economic, public health engineering and dietary improvements as major factors. See McKeown (1976); McKeown and Brown (1955); McKeown and Record (1962); McKeown and Lowe (1966); McKeown *et al.* (1972).

Dr David Misselbrook FRCGP (b. 1956) has been a General Practitioner in South London since 1984. He was Honorary Clinical Tutor at the United Medical and Dental School (UMDS) of Guy's and St Thomas's Hospitals from 1988–98 and seminar leader from 1990–94; General Practice Trainer from 1991 and GP VTS Course Organizer from 1992–2002. He has been a Board Member of the Faculty of the History and Philosophy of Medicine of the Society of Apothecaries of London from 2004 and is a lecturer and examiner for the Diploma in the Philosophy of Medicine of the Society of Apothecaries.

Professor David Morton BVSc PhD CBiol FIBIOL DipECLAM MRCVS (b. 1943) was appointed Research Fellow at the Agricultural Research Council Unit of Reproductive Physiology

and Biochemistry, Strangeways' Research Laboratory, Cambridge from 1970 to 1978; Director of Biomedical Services and Senior Lecturer in Human Anatomy at the University of Leicester from 1978 to 1989; Director of the Unit of Biomedical Services and Professor and Head of the Centre for Biomedical Ethics at the University of Birmingham from 1989 to 2006. He was Chair of the Royal College of Veterinary Surgeons (RCVS) and British Veterinary Association (BVA) Working Party on Animal Experimentation (1984–88); Government adviser on the Animals (Scientific Procedures) Bill (1984–86); Adviser to the Economic and Social Committee of the EED on the Directive regarding the Protection of Animals used for Experimental and other Purposes (1987–92); Member of the Medical Ethics Working Party for the Study of the Ethics of Using Animals in Medical Research (1987–90); Chair of the OECD Working Party on Humane Endpoints in Toxicity Testing (1995/6); Member of the European Union (EU)/ European Food Safety Authority (EFSA) Scientific Committee on Animal Health and Animal Welfare (1998–2006); Member and Chair of the British Pregnancy Advisory Service Research and Ethics and Clinical Governance Committee

(1993–); Member of the Farm Animal Welfare Council (2004); Member of the Companion Animal Welfare Council (2006). He was awarded the 1993 RCVS Livesey Medal for the relief of animal suffering; the 1995 Research Defence Society/Smith Kline Beecham Animal Welfare Prize; the 2002 Russell and Burch prize for outstanding contributions to the Three Rs. See Russell and Burch (1959) and note 70.

Dr Richard Nicholson

studied chemistry and medicine at Oxford University and The London Hospital and was in general practice. He founded the *Bulletin of Medical Ethics* in 1985 and has been both editor and publisher of the now independent publication. He set up a working party on the ethics of research with children and wrote its report, which included a thorough survey of research ethics committees [Nicholson (ed.) (1986)]. He has been a member of the London Multi-centre Research Ethics Committee, and chairman of the Association of Research Ethics Committees, which he also founded.

Professor Nel Noddings

PhD (b. 1929) was the Jacks Professor Emeriti of Child Education at Stanford University

from 1992 until her retirement in 1998 and also holds the John W Porter Chair in Urban Education at Eastern Michigan University. She gained a bachelor's degree in mathematics from Montclair State College, New Jersey; a Master's degree in mathematics from Rutgers University, New Jersey; and a Doctorate in educational philosophy from Stanford University. From 1949 to 1972, she was an elementary and high school teacher and administrator in New Jersey public schools. After receiving her PhD in educational theory and philosophy from the University of Stanford in 1975, she joined the faculty there in 1977. She was an outstanding teacher there and served in various positions including as acting dean of the School of Education. She taught the philosophy of education at Columbia University, New York, until 2000.

Dr Maurice Pappworth

FRCP (1910–94) qualified at Liverpool University with junior appointments in Liverpool, including assisting Lord Cohen, but was unsuccessful when applying for a consultant job in Liverpool and elsewhere later [see Booth (1994); Lock (2000)]. He served in the Royal Army Medical Corps finishing as a lieutenant-colonel, and moved into private practice in London and concentrated on

private postgraduate teaching for the MRCP, publishing a text for that purpose [Pappworth (1960)]. From his contacts in the London teaching hospitals, he learned of increasing concerns about unethical experiments on patients. He published 14 cases in 1962 and five years later described 205 experiments on institutionalized individuals and 78 from NHS hospitals. Soon after, a Royal College of Physicians' working party led to the formation of ethics committees [Royal College of Physicians (1967)]. He was eventually elected to a Fellowship of the College, 57 years after gaining his Membership. See Pappworth (1990).

Dr Brian Payne

FRCP (b. 1945) was Student Secretary, London Medical Group, from 1969–70. He was Consultant Physician in Geriatric Medicine at the Norfolk and Norwich University Hospital, Norfolk, from 1978 to 2006; and a founder member of the hospital's Clinical Ethics Group, affiliated to ETHOX (Oxford Centre for Ethics and Communication in Health Care Practice).

Sir John Peel

KCVO FRCS FRCOG (1904–2005), trained at King's College Hospital, London, specializing in

obstetrics and gynaecology there, specifically the pregnant diabetic, remaining at Denmark Hill during the Second World War, until his retirement in 1969, staying on as consulting surgeon. He was also a consultant at the Princess Beatrice Hospital, London, from 1937 to 1965 and director of clinical studies at King's College Hospital Medical School from 1948 to 1967. He succeeded Sir William Gilliatt as surgeon-gynaecologist to the Queen in 1956. He was President of the Royal College of Obstetricians and Gynaecologists from 1966–69, during the introduction of abortion law reform and chaired the committee advising the Government on the passage of the bill. He united a divided profession, pursuing his personal aim to reduce the disease and death associated with illegal abortion. He was President of the British Medical Association in 1970 and of the Family Planning Association, 1971–74. See Peel (1961).

Sir Desmond Pond

Kt MD FRCP FRCPsych
HonFRCGP (1919–86) was a Rockefeller Scholar at Duke Medical School, Durham, North Carolina, from 1942 to 1944; appointed Senior Lecturer in the Department of Clinical Neurophysiology at the Maudsley

Hospital, London, and Consultant Psychiatrist at University College Hospital, London, from 1952 to 1966; and Professor of Psychiatry in the University of London at the London Hospital Medical College, from 1966 to 1982. He was Chief Scientist at the Department of Health and Social Security (DHSS) from 1982 until his retirement in 1985. He was a Founder Member of the Institute of Religion and Medicine (1964); a member of the Archbishop's Group on Divorce Law (1964–66); a member of the Medical Research Council (1968–72; 1982–85); and President of the Royal College of Psychiatry (1978–81). He died shortly before the publication of the Pond Report [Boyd (1987)]. See also Pond (1973).

The Rt Revd Professor Ian Ramsey (1915–72) was Nolloth Professor of the Philosophy of the Christian Religion at the University of Oxford, and Fellow of Oriel College, 1951–66, and Bishop of Durham from 1966 until his death.

Dr Bernard Reiss

OBE (1925–96) worked in general practice in Cambridge from 1959 until his retirement in 1990. Along with Dr Ian Tait, he was the first Regional Adviser in General Practice for East Anglia. He was involved in the foundation of the

Clinical School at Cambridge University in 1976 and was the first Director of GP Studies there.

Professor Povl Riis

MD DMSci FRCP (b. 1925) was Physician-in-chief of the medical department of the Gentofte Hospital, Copenhagen from 1963 to 1976; Physician-in-chief, gastroenterology, at the Herlev University Hospital, Copenhagen, from 1976 to 1996. He was editor-in-chief of the *Journal of the Danish Medical Association* from 1957 to 1991; a member of the editorial board of the *Journal of the American Medical Association* since 1994 and Chairman of the Nordic Cooperative Board for Medical Science from 1970–72 and the Danish Medical Research Council from 1972–74; Chairman of the National Sciences Ethical Committee for Medicine from 1979–98 and Chairman of the Age Forum since 1996.

Max Leonard Rosenheim, Baron Rosenheim of Camden KBE FRCP FRS (1908–72), son of a naturalized German father, he qualified and held junior appointments at University College Hospital (UCH) and Westminster Hospital, London, 1932–38; was Research Assistant at Massachusetts General Hospital, Boston, MA, as a Bilton Pollard travelling

fellow and First Assistant, Medical Unit, UCH in 1939. He joined the Royal Army Medical Corps, 1941–46, serving in the Middle East, North Africa and Europe; later consulting physician to the Allied land forces, South-East Asia, where he developed a lasting interest in tropical diseases. He was appointed Physician at University College Hospital, 1946–50 and succeeded (Sir) Harold Himsworth as Professor of Medicine, University of London, and Director, of the Medical Unit, UCH Medical School, 1950–71, later Emeritus, where he was a gifted administrator and clinician. He was a Member of the Medical Research Council, 1961–65; a very active President of the Royal College of Physicians, London, 1966–1972, where he was instrumental in unifying the three colleges' [London, Edinburgh and Glasgow] Membership examination and agreeing a Faculty of Community Medicine following the Todd Report. He was elected an Honorary Fellow of UCL in 1967. See Robson (1982).

Professor David Rothman

PhD trained in American social history at Harvard University and wrote about the history of mental hospitals, prisons and almshouses. He joined the Columbia Medical School faculty in 1983 and has been the Bernard Schoenberg

Professor of Social Medicine and Director of the Center for the Study of Medicine, Columbia College of Physicians & Surgeons and Professor of History at Columbia University. He chairs the Program on Medicine as a Profession for the Open Society Institute. He wrote the first full history of bioethics in the US by a trained historian [Rothman (1991)].

Mr Brian Salmon

CBE (1917–2001), businessman, was Chairman of the family firm of J Lyons & Co. Ltd from 1972 to 1977, where he had been Director (1961–77), Joint Managing Director (1967–69) and Deputy Chairman (1969–71). His involvement in the health service began in 1949, when he chaired the catering committee of Westminster Hospital, London, where he was later Vice-Chairman of the Board of Governors (1963–74). He chaired the committee advising the Ministry of Health on nursing staff structure (1963–66) [Ministry of Health (1966)]. He was Chairman of the Camden and Islington Area Health Authority (1974–77) and a member of the Department of Health and Social Security's Supply Board Working Group (1977/8). For details of the Salmon Report, see www.nhshistory.net/1958-1967.htm (visited 1 May 2007).

Dame Cicely Saunders

OBE DBE OM FRCP FRCS (1918–2004) founder and Medical Director of St Christopher's Hospice, Sydenham, London, from 1967 to 1985 and Chairman from 1985 to 2000, first trained in nursing, qualified, but back pain barred practising. She returned to St Anne's, Oxford, gaining her diploma in Public and Social Administration and a war degree, becoming a Lady Almoner at St Thomas' Hospital in 1947. She was also a volunteer sister at St Luke's, Bayswater, London, where she learned to use analgesics at regular intervals. She read medicine, and trained at St Thomas', qualifying in 1957. She started as Halley Stewart Research Fellow under Professor Harold Stewart, St Mary's Hospital Medical School, London, working at St Joseph's Hospice, Hackney, in 1958 on pain in the terminally ill. Her 'scheme' of 1959 was a proposal for a 100-bed home for those dying of cancer and other diseases where pain could be controlled and symptoms alleviated. St Christopher's was established as a charity in 1961 and received its first patients in 1967. She was a member of the Medical Research Council from 1976 to 1979 and Honorary Consultant at St Thomas' Hospital since 1985. See du Boulay (1984). See also Figure 6.

The Very Revd Edward Shotter BA HonFRCP (b. 1933) was ordained Deacon in 1960 and Priest in 1961, served as assistant curate at St Peter's, Plymouth, 1960–62; intercollegiate secretary, Student Christian Movement, London, 1962–66, Chaplain to the University of London, 1969–89; Prebendary of St Paul's Cathedral, London, 1977–79. He was Director of Studies of the London Medical Group from 1963–89, Director of the Institute of Medical Ethics, 1974–89, and was instrumental in founding the *Journal of Medical Ethics* in 1975. He chaired a joint British Medical Students' Association/ LMG Committee on the welfare of Czech and Slovak medical students in Britain, 1968/9; a member of the Archbishop of Canterbury's Counsellors on Foreign Relations, 1971–82; the British Council of Churches East–West Relations Advisory Committee, 1971–81; chairman, East Europe subcommittee, Liberal Party Foreign Affairs Panel, 1974–81. He chaired the IME Working Party on the Ethics of Prolonging Life and Assisting Death, 1993–97; the University of Greenwich Research Ethics Committee, 1995–2003; was a member of the Education Committee of St Christopher's Hospice, Sydenham, London,

1982–89; Dean of Rochester, 1989–2003; and joint chairman and Force Chaplain, Kent Police Chaplaincy, 1993–2001. He was secretary of the Association of English Cathedrals, 1994–2002 and a member of the General Synod, 1994–2003. He has been chairman of the HMS Cavalier Memorial Steering Group since 1999 and a Vice-President of the Institute of Medical Ethics since 2000. He was elected an Honorary Fellow of the Royal College of Physicians in 2007. See Shotter (ed.) (1970). See also Figure 6.

Professor Peter Singer

BPhil (b. 1946), born in Melbourne, Australia, was Radcliffe Lecturer in Philosophy at University College, University of Oxford, from 1971 to 1973. He wrote *Animal Liberation* (1975) while at Oxford and during a visiting professorship at New York University in 1973/4. Returning to Australia, he was a Lecturer at La Trobe University (1975/6), appointed Professor of Philosophy at Monash University in 1977, directed the university's Centre for Human Bioethics in 1983 and was co-director of its Institute for Ethics and Public Policy in 1992. He has been Ira W DeCamp Professor of Bioethics in the University Center for Human Values at Princeton University, New Jersey, since 1999. See Singer (1975).

Dr Ian Tait

MD FRCGP (b. 1926) was in general practice in Aldeburgh, Suffolk, from 1959 to 1990 and was active in the initiation and development of vocational training for general practice in East Anglia from 1969 onwards. He was Associate Regional Adviser for East Anglia; Nuffield Travelling Fellow in 1970 on the subject of behavioural science in medical education and clinical practice [Tait (1973)]; Royal College of General Practitioners Jephcott Visiting Professor to University College Hospital (UCH), London, in 1976; received the Shearing Award in 1989 for ‘The teaching of medical ethics in GP vocational training schemes’, a report to the RCGP Ethics Committee.

Dr E M (Tilli) Tansey

PhD PhD HonMRCP FMedSci (b. 1953) is Convenor of the History of Twentieth Century Medicine Group and Reader in the History of Modern Medical Science at the Wellcome Trust Centre for the History of Medicine at UCL, London.

The Revd Bryan Vernon

MA Dip Theol (b. 1950), Anglican chaplain, was educated at Queens’ College, Cambridge, and The Queen’s College, Birmingham, and served as University Anglican

Chaplain at Newcastle University from 1979 to 1991. He has been Lecturer in the Ethics of Healthcare at Newcastle University since 1991 and was Chair of the Newcastle Mental Health NHS Trust from 1991 to 1994.

Lord Walton of Detchant

TD Kt FRCP (b. 1922) was Professor of Neurology from 1968 to 1983 and Dean of Medicine from 1971 to 1981 at the University of Newcastle upon Tyne. He was Warden of Green College, Oxford, from 1983 to 1989. He served on the MRC from 1974 to 1978 and has been a member of the House of Lords Select Committee on Science and Technology since 1991.

Mary Warnock

Baroness Warnock of Weeke

DBE FRCP Hon FBA (b. 1924) was Fellow and Tutor in Philosophy, St Hugh’s College, Oxford, 1949–66; Headmistress of the Oxford High School, 1966–72; Talbot Research Fellow, Lady Margaret Hall, Oxford, 1972–76; and Senior Research Fellow, St Hugh’s College, Oxford, 1976–84, Honorary Fellow, in 1985. She was Mistress of Girton College, Cambridge from 1985 to 1991. She was a member of the Independent Broadcasting Authority, 1973–81; Chairman of the Committee of

Inquiry into Special Education, 1974–78; a member of the Royal Commission on Environmental Pollution, 1979–84; Chairman of the Advisory Committee on Animal Experiments, 1979–85; a member of the Social Science Research Council 1981–85; Chairman of the Committee of Inquiry into Human Fertilisation, 1982–84; a member of the Committee of Inquiry into Validation of Public Sector Higher Education, 1984; Chairman of the Committee on Teaching Quality, 1990; a member of the European Advisory Group on Bioethics, 1992–94 and of the Archbishop of Canterbury’s Advisory Group on Medical Ethics, since 1992. See Warnock (1960, 1998).

Professor R B (Dick) Welbourn FRCS (1919–2005) was Professor of Surgery and Director of the Department of Surgery at the Royal Postgraduate Medical School at Hammersmith Hospital, London, from 1963 to 1979, and Professor of Surgical Endocrinology and Honorary Consultant Surgeon there from 1979–82, later Emeritus. He was an adviser to the LMG, serving on its Consultative Council. He was Chairman of the LMG Postgraduate Advisory Group, which led to the formation of the Society for the Study of Medical Ethics (the Institute

of Medical Ethics (IME) since 1984) and Chair of the editorial committee of the *JME* (1974–81). He was the Vice-Chairman of the IME’s Governing Body and Vice-President of IME, until his death in 2005. He jointly edited the *Dictionary of Medical Ethics* (1977) with Professor Archie Duncan and Professor Gordon Dunstan. See Figure 11.

Dr Michael Wilks

worked in general practice in West London from 1977 to 1992. He then specialized in forensic medicine and is now a Senior Forensic Medical Examiner in the Metropolitan Police. He was a member of the BMA’s Medical Ethics Committee from 1994 and chaired the committee for nine years until 2006 and was Chairman of the BMA’s policy-making forum, the Representative Body, until 2007. He was involved in setting up the BMA’s ‘Doctors for Doctors unit’, is a trustee of the Sick Doctors Trust, and is chairman of the trustees of the Rehabilitation of Addicted Prisoners Trust. From January 2008, he will be President of the Standing Committee of European Doctors, which represents the interests of all doctors working in the European Union’s 27 member-states.

Dr Peter Wilkinson

MA FRCPath (b. 1945) has been Head of Clinical Governance for the Health Protection Agency (HPA) since 2005. While a clinical medical student at King's College Hospital, London, from 1967 to 1970 he was a representative for the London Medical Group (LMG) and its President in 1968/9. After qualifying and house jobs, he trained in clinical pathology at Bristol where, with others, he established the Bristol Medical Group in 1973. On completion of his specialist training in medical microbiology, he was an Alexander von Humboldt Research Fellow in Munich, Germany, 1976–78 and Consultant Senior Lecturer in Microbiology at the University of Bristol, 1978/9. He was then appointed by the Public Health Laboratory Service (PHLS) as a Consultant Medical Microbiologist and Director of the Public Health Laboratories in Plymouth, 1979–93 and in Nottingham, 1993–96, after which he was Group Director of the Trent Group of laboratories from 1996 to 2003. In 2003 some of the PHLS became part of the Health Protection Agency (HPA) and he was Regional Microbiologist for East Midlands from 2003 to 2005 before taking up his present appointment. Though his career has been largely in laboratory

medicine and management, he was able to continue ethical interests through his involvement, while in Plymouth, with the management of St Luke's Hospice, and Broadreach House, a centre for the treatment of addiction.

Dr Luke Zander

FRCP FRCGP (b. 1935), a General Practitioner in Lambeth, was Senior Lecturer in the Department of General Practice at the United Medical and Dental Schools of Guy's and St Thomas' Hospitals, London until his retirement. His interest in home births arose through his concern for respecting his patients' choices. He founded the multidisciplinary Forum on Maternity and the Newborn at the Royal Society of Medicine, and was a founder member of the Association for Community-based Maternity Care. He was an adviser to the Parliamentary Select Committee on Health for its report on the maternity services (1992) and is a past adviser to the National Perinatal and Epidemiology Unit in Oxford and to the National Childbirth Trust. He is a past President of the General Practice Section at the Royal Society of Medicine. He chairs the editorial board of the *Bulletin of Medical Ethics*.

Glossary*

Abortion Act, 1967

Abortion was made illegal by the Offences against the Person Act, 1861. The Infant Life Preservation Act, 1929, amended the law to permit termination solely to preserve the life of the mother and made it illegal to kill a child ‘capable of being born live’, setting the viability of the fetus at 28 weeks. David Steel’s private member’s bill led to the Abortion Act of 1967, which came into effect in 1968 in England, Scotland and Wales, but not Northern Ireland. The Human Fertilization and Embryology Act, 1990 reduced the age of fetal viability to 24 weeks. For further details see www.bpas.org/abortions/legal.html (visited 14 June 2007). For discussion of the working of its effects, see the Committee on the Working of the Abortion Act [Lane Report] (1974); Kandiah and Staerck (eds) (2002).

Animals (Scientific Procedures) Act, 1986

UK legislation regulating experiments on animals, which updated the pioneering Cruelty to Animals Act 1876, and preserved its main features.

Bioethics

The study of ethical, social, legal, philosophical and other related issues, and their implications, arising in healthcare and the biological sciences. See Chadwick (2007); see also www.wellcome.ac.uk/doc_WTX022192.html (visited 14 June 2007).

British Society for Social Responsibility in Science

A group established in 1969 to stimulate an awareness of the social and ethical significance of science among scientists themselves and of their individual and collective responsibilities. At its peak in the early 1970s, it had 1200 members and a dozen working groups with a similar number of local groups. It published a newsheet, specialty journals as well as longer research monographs; and organized public meetings. The working groups included the Hazards Group; the Technology of Political Control Group; the working group on food (forerunner of the London Food Commission); and the Radical Statistics Health Group, which continues to monitor priorities for health and personal social services. Many of the original

* Terms in bold appear in the Glossary as separate entries

activists became involved in spin-off activities or assumed external responsibilities and the group wound down in the early 1990s due to lack of new members, donating part of their remaining funds to the Scientists for Global Responsibility. Their archives have recently been donated to the Science Museum. See Burhop (1971); Dickson (1971). See also Rose and Rose (1969); Pirani (1970); Werskey (1971); Fuller (ed.) (1971) and Rose (2003).

Code on Human Experimentation

A set of five rules concerning human experimentation drawn up by the WMA's Medical Ethics Committee in 1955, which covered: scientific and moral aspects of experimentation; prudence and discretion in the publication of the first results of experimentation; experimentation on healthy subjects; experimentation on sick subjects; the necessity of informing the person who submits to experimentation of the nature of the experimentation, the reasons for the experiment and the risks involved. These were revised in 1961 as the 'Draft Code of Ethics on Human Experimentation' and presented to the 15th WMA General Assembly. The final version of 12 principles was adopted by the 18th World Medical Assembly (Helsinki, 13–14 June 1964),

known as the **Declaration of Helsinki**. See WMA (1962, 1964).

Consensus statement (1998)

Core curriculum for medical ethics and law proposed by teachers of medical ethics and law in UK medical schools. The 12 topics suggested were: informed consent and refusal of treatment; the clinical relationship: truthfulness, trust, and good communication; confidentiality; medical research; human reproduction; the new genetics; children; mental disorders and disabilities; life, death, dying, and killing; vulnerabilities created by the duties of doctors and medical students; resource allocation; and rights. See Consensus Statement by teachers of medical ethics and law in UK medical schools (1998).

Declaration of Geneva – See **Hippocratic Oath**.

Declaration of Helsinki –

A statement of basic ethical principles adopted by the World Medical Association (WMA) in 1964, from the **Code on Human Experimentation** to 'provide guidance to physicians and other participants in medical research involving human subjects'. It has been amended eight times, most recently in October 2000. The 1975 Declaration emphasized the rights of the individual

patients or subjects concerning consent and welfare, while stating that the purpose of biomedical research is: ‘to improve diagnostic, therapeutic and prophylactic procedures and the understanding of the aetiology and pathology of disease’. Experiments should respect the environment and the welfare of animals used. Authors were accountable for obtaining and stating consent, while journal editors were to monitor this obligation and reject reports of experimentation conducted outside the recommendations of the Declaration. The full code can be found in BMA (1988): 99–102. See also Bennett and Nakamura (1964); WMA (1964, 1996). For further information, see www.rotf.org/information/Helsinki_declaration.pdf; freely available at www.cirp.org/library/ethics/helsinki/ (visited 28 March 2007).

Ethical Committee (UK)

A committee that reviews the ethical practice of research undertaken by their staff, whether in a NHS local health district, a primary care trust or a private hospital. In the matter of consent, the MRC’s 1963 statement on the responsibility in investigations on human subjects distinguished between procedures of benefit to the patient and those contributing to medical knowledge [see **Human**

experimentation and clinical research] and that the patient must be competent to give that consent. The implementation of local ethical committees began with the Royal College of Physicians’ working party in 1967 to consider their responsibility to the public [RCP (1967), according to Pappworth (1990): 1457, not widely available until 1973] and recommended that all research be subject to ethical review. The Department of Health and Social Security (DHSS) recommended that hospitals should establish ethics review boards with no compulsion. The 1975 revision of the Helsinki Declaration promoted the submission of clinical trial protocols to an independent committee. Guidelines were also prepared by the Royal College of Physicians in 1984 [Alberti (1995): 639] and the DoH [DoH (1989)], while mandatory requirements were not imposed on every health district to have a local research ethics committee until 1991 [DoH (1991)]. For ethical committees relating to clinical treatment, see BMA (1988): 123–7; Royal College of Physicians (2007).

General Medical Council (GMC)

A national body responsible for keeping up-to-date registers of qualified doctors in the UK [England and Wales, Scotland and Northern Ireland]; encouraging

good medical practice; promoting high standards of medical education and undertaking disciplinary procedures for doctors whose ‘fitness to practise’ is in doubt. It was established under the Medical Act of 1858 and operates under the regulation of the Medical Act 1983, as amended in November 2004. The register is published annually as the *Medical Directory*, and forms the basis of the GMC’s annual statistics on the profession. For further details on available ethical guidance for UK doctors, see www.gmc-uk.org/register/index.asp (visited 20 June 2007).

Hippocratic Oath

A modern restatement of the Hippocratic Oath, known as the **Declaration of Geneva**, approved by World Medical Association in 1948. Although not formally sworn in many UK medical schools, it is considered as being made at the time of being admitted as a member of the medical profession [BMA (1988): 57–8].

I solemnly pledge myself to consecrate my life to the service of humanity;

I will give to my teachers the respect and gratitude which is their due;

I will practise my profession with conscience and dignity;

The health of my patient will be my first consideration;

I will respect the secrets which are confided in me, even after the patient has died;

I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;

My colleagues will be my brothers;

I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patients;

I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I make these promises solemnly, freely and upon my honour.

For one of many modern variations, written by Dr Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, Boston, Massachusetts, in 1964, see www.pbs.org/wgbh/nova/doctors/oath_modern.html (visited 16 June 2007). See also Boyd (ed.) (1987): 5–6.

Human experimentation and clinical research

The three categories are: empirical clinical trial in the course of medical treatment; self-experimentation; and deliberate trial or experiment on subjects not for their immediate specific benefit but to gain knowledge. See Paton (1994): 263.

Human Fertilization and Embryology Authority (HFEA)

A statutory body created in 1991 under the Human Fertilization and Embryology Act 1990 to license and monitor UK clinics that offer IVF (*in vitro* fertilization) and DI (donor insemination) treatments, and all UK-based research into human embryos, as well as regulating the storage of eggs, sperm and embryos, including a database of every IVF treatment and one of every egg and sperm donor. See www.hfea.gov.uk/en/272.html (visited 18 July 2007).

Informed consent

True consent, as distinguished from assumed consent or consent obtained by undue influence, is one freely given by an adult of sound mind with proper understanding of the nature and consequences of what is proposed and supported by evidence of this understanding obtained in the company of a witness. For the young, those with mental abnormalities or disorders, the application of this principle becomes more difficult [MRC (1964): 179]. The literature divides on consent to treatment or consent for medical research, and attention has been drawn to double standards in treatment with respect to safety. See Faden and Beauchamp (1986); Chalmers and Lindley (2001); Doyal and Tobias (2001); Oxman *et al.* (2001); Hope (2004).

Institute of Medical Ethics (IME)

An independent non-partisan body that promotes the multidisciplinary study of issues raised by the practice of medicine. It publishes the monthly *Journal of Medical Ethics*. The **Society for the Study of Medical Ethics** changed its name to the IME in 1984. See Appendix 1, pages 96–108.

Institute of Religion

Founded at the Texas Medical Center (TMC) in Houston, Texas, in 1955 to support the religious and spiritual aspects of health and healing within the Medical Center's institutions; and to provide chaplaincy training and clinical pastoral education in co-operation with TMC hospitals until their independence in the 1980s. See www.religionandhealth.org/default.htm (visited 1 February 2007).

Institute of Religion and Medicine

An association of doctors and clergy formed in 1964 to improve communication between the two professions and to study problems of common concern. The Archbishop of Canterbury (Michael Ramsey) was its first President. The LMG's Director was a member of the Institute's Education Committee, and a formal relationship between the two was under discussion in 1965/6, but was rejected by the

LMG Governing Body. *LMG Annual Report 1965*: 4, 11. See also Melinsky (ed.) (1970).

International Council of Nurses (ICN)

A federation of national nurses' associations (NNAs) representing nurses in more than 128 countries founded in 1899 to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce. See www.icn.ch/abouticn.htm (visited 7 June 2007).

Journal of Medical Ethics (JME)

Journal of the **Society for the Study of Medical Ethics** (SSME) [Institute of Medical Ethics from 1984], co-owned with BMJ Journals, and one of the first international journals to deal solely with medical ethics, and is still one of the world leaders. It was launched at a press conference held at the Royal Society of Medicine on 23 April 1975 followed by a dinner given by Lord Amulree at the Reform Club. Dr [now Professor] Alastair Campbell as the first editor (1975–80), followed by Professor Raanan Gillon (1980–2001). See Appendix 1, pages 71–121 and note 226. For further details of the current editorial board, see [\[jme.bmj.com/info/edboard.dtl\]\(http://jme.bmj.com/info/edboard.dtl\) \(visited 7 August 2007\). It replaced *Documentation in Medical Ethics*, which was distributed to SSME members as part of their annual subscription. See Appendix 1, note 166.](http://</p></div><div data-bbox=)

Medical Directory

An annual list of medical practitioners, first published in 1845, compiled from the returns from those whose names appear in the Principal List of the Register kept by the **General Medical Council** of the UK. It is not to be confused with the Register, as listing in the *Directory* is optional. For further information, see www.pjbpubs.com/medical_directory/about.htm and www.gmc-uk.org/register/index.asp (visited 20 June 2007).

Medical education

A form of professional training in medicine in three parts in the UK: the first of about five years' duration covers basic education in medical sciences including student-selected components through which medical ethics is now delivered, with clinical experience in the last two years, funded and organized by the universities, whose successful completion gains a MBChB; the second phase of Postgraduate Medical Education (PGME), a period of clinical

training to make a generally trained clinician of the medical graduate, funded through the university via a grant from central government; with the third stage being specialist education, including general practice, whose standards are controlled by the specialist boards, mainly Royal Colleges, funded from the Department of Health, with the overall responsibility for the coordination of the medical training in the hands of the **General Medical Council**. The successful completion of the third phase is documented by the Certificate of Completion of Specialist Training (CCST), denoting eligibility for appointment as a consultant. See also **Todd Report**; Doxiadis (ed.) (1990); DoH [Calman Report] (1993); www.nhshistory.net/medical_education.htm (visited 23 July 2007).

Medical ethics

Traditionally considered to cover standards of professional competence and conduct, monitored by a national medical body to maintain standards. The Nuremberg Trials and subsequent **Code** elevated ethical principles of moral philosophy to the consideration of medical professionals, including beneficence, non-maleficence; respect for autonomy and justice. Modern teaching of medical ethics

has included the encouragement of critical thinking, etiquette towards patients and the skills of medical communication and the maintenance of minimum standards. For a timeline of the development of ethical practice in medicine, see <http://wisdomtools.com/poynter/codes.html> (visited 31 May 2007). For a sample syllabus, as used in the Oxford Practice Skills Course, see Hope *et al.* (1996).

Nuremberg Code

Formulated in part by a team of US physicians at the Nuremberg Trials and part by the Nuremberg Trials' judges while preparing the 1946 verdict, this code established the principle of respect for persons, for human dignity and the right of persons to make choices for themselves; that the voluntary consent of the human subject of medical research was 'essential'. The restrictive wording of the Code excluded much of health research. See Riis (2001).

Pond Report (1987)

Report of a Working Party on the *Teaching of Medical Ethics* appointed by the **Institute of Medical Ethics** in 1984, composed of 13 members and a research team/secretariat of five, funded by the Nuffield Foundation and chaired by Sir Desmond Pond, who died in 1986. Seven members

involved with the Report attended the Witness Seminar: three members of the Pond Working Party: Professors Roger Higgs and Bryan Jennett, and the Very Revd Edward Shotter. In addition were members of the Research Team: Professor Kenneth Boyd, Fr Brendan Callaghan, Professor Raanan Gillon and Dr Richard Nicholson. A survey was sent to the Deans of the 30 British medical schools, covering their policy on ethical teaching; timetabled periods of teaching; the encouragement of informal discussion; non-medical teachers; assessment and encouragement of student's familiarity with ethical issues; extra-curricular activities; and the respondent's own views on medical ethics teaching. The responses of the 26 Deans who replied were analysed in Chapter 3 [Boyd (ed.) (1987): 15–34]. See Figure 10.

Principlism

An ethical approach based on the four fundamental moral principles of autonomy, beneficence, non-maleficence and justice, developed by Beauchamp and Childress [(1979)].

Society for the Study of Medical Ethics (SSME)

An independent non-partisan body which promotes the multidisciplinary study of issues

raised by the practice of medicine. It publishes the monthly *Journal of Medical Ethics*. It was developed out of the LMG's Postgraduate Advisory Group of former student reps in 1972 in London to influence both professional and public discussion of the moral consequences of medical practice, to ensure that this developing subject achieved a proper autonomy and that multidisciplinary discussions were not unduly influenced by any one of the non-medical interests. It relied upon the small secretariat of the LMG to service its membership, and prepare and distribute *Documentation in Medical Ethics*, its reprint service, which was replaced by the *Journal of Medical Ethics* in 1975. The first Chairman was Professor R B Welbourn and the editors in 1974 were Roger Higgs, Richard Nicholson, Edward Shotter and Anthony Thorley. See Appendix 1, pages 98–100.

Todd Report (1968)

The *Report on medical education* [Royal Commission on Medical Education (1968)] named for its Chairman, Alexander, Baron Todd of Trumpington. It reorganized the structure of medical education, requiring more emphasis on the behavioural sciences (psychology, sociology and related disciplines) and introduced 'professional bodies'

in the specialties to assess skills at the end of the postgraduate training period, regulated by the Councils for Postgraduate Education [since 2005 this is an independent regulatory body known as the Postgraduate Medical Education and Training Board, who supervise quality control of training programmes and certify doctors' proficiency through the Certificate of Completion of Training]. Todd's critical decision was to treat general practice as a specialist career, requiring a suitable programme of postgraduate education, three years' post-registration 'general professional training' and two further years' 'further professional training' in general practice, and led to the introduction of mandatory vocational training. The teaching of ethics became an important part of this training. See Calman (2007): 280–4. For a timeline of training in general practice, see www.rcgp.org.uk/services__contacts/history_heritage__archives/history__chronology/chronology/chronology_by_subject/education_and_training.aspx (visited 26 July 2007).

Tomorrow's Doctors (1993)

The GMC's new core curriculum for the training of clinical medical students in England and Wales, which included ethics, law and communication [GMC (1993),

revised (2003)]. For a sample course for teaching of key skills in medical ethics developed within this structure, including a comprehensive list of background readings, see Hope *et al.* (1996). See also Figure 8.

Warnock Report (1984)

Following the birth of the first *in vitro* fertilization (IVF) baby, Louise Brown, in 1978, the UK Government appointed a committee in 1982 under the chairmanship of Dame Mary Warnock (Baroness from 1985) to consider new reproductive options for human assisted reproduction, including external *in vitro* fertilization (IVF) and surrogacy, as well embryology research. The *Report* [Committee of Inquiry into Human Fertilisation and Embryology (1984)], much admired internationally, recommended policies and safeguards for medicine and science; put forward a new statutory licensing authority to regulate both research and infertility services; outlined stringent controls on the use of human embryos; suggested anonymity of those donating gametes for infertility treatment; requested a review of arrangements for the provision of local authority infertility services; and proposed legal protection

for human embryos. There were three dissenting views. See Gillon (1987b); Nelson (2005).

World Medical Association (WMA)

Formed in 1946 as a forum for the discussion of medical practice and conditions of medical service and medical education, the first General Assembly of 27 national medical associations was held

in 1947 in Paris, France. It also aimed to raise the general standards of professional conduct and established a Committee on Medical Ethics in 1952, whose work formed the basis for the Declaration of Helsinki. See **Code on Human Experimentation; Helsinki Declaration; Declaration of Geneva**. See also BMA (1988): 95–112.

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